DOCUMENT RESUME

ED 089 161 CG 008 745

TITLE	Putting Children First: A Reorganization Proposal for Children's Services
INSTITUTION	Massachusetts Committee on Children and Youth, Boston.
PUB DATE	Jun 73
NOTE	86p.; A report of the Task Force on Children's Services
EDRS PRICE	MF-$0.75 HC-$4.20 PLUS POSTAGE
DESCRIPTORS	Agency Role; *Child Welfare; *Community Agencies (Public); Conference Reports; Foster Children; *Social Problems; *Social Services; *State Programs

ABSTRACT

This document summarizes the deliberations of the Task Force on Children's Services of the Massachusetts Committee on Children and Youth. The Task Force makes the following recommendations: (1) a preventive approach should be substituted for the current policy of dealing with problems only after crisis proportions have been reached or irreparable damage has been done; (2) all programs for children currently scattered throughout the State government should be integrated into a single children's services system; (3) each area should have a children's services agency which would supervise all State-supported children's services in the area with emphasis on prevention; (4) a children's services agency should also be established at the State level which would conduct specialized activities and assist the areas with their duties under State-supervised guidelines; and (5) additional funds should be appropriated at the State and Federal levels, both to provide adequate services for children and to improve the physical and social environments in which children develop. (Author/RWP)

ED 089161

PUTTING CHILDREN FIRST:

A REORGANIZATION PROPOSAL FOR CHILDREN'S SERVICES IN MASSACHUSETTS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

A Report

of the

Task Force on Children's Services

CG 008 745

Massachusetts Committee on Children and Youth
9 Newbury Street
Boston, Massachusetts 02116

June 1973

Task Force on Children's Services
Massachusetts Committee on Children and Youth

Members

Adam Yarmolinsky, Chairman, Boston
Robert H. Gardiner, Vice-Chairman, Milton

Vernon R. Alden, Brookline
Ruth M. Batson, Boston
James L. Bell, Springfield
Thomas S. Bennett, Martha's Vineyard
Rose Claffey, Salem
Robert Bonner Clifford, Framingham
Frieda Garcia, Boston
Jean B. Griesheimer, Worcester
Andrew D. Guthrie, Jr., M.D., Medford
James A. Hooley, Hanover
Margaret Lynch, Cohasset
Honorable Arthur M. Mason, Framingham
John R. McGaughey, Bridgewater
Theresa J. Morse, Brookline
Robert M. Mulford, Winchester
Arthur Z. Mutter, M.D., Newton Centre
Reverend James A. Nash, Ph.D., Burlington
Eveoleen N. Rexford, M.D., Cambridge
Helen B. Rochlin, Cambridge
Mel Shea, Bridgewater
Margaret A. Sullivan, Newton Centre
Donald R. Taylor, Sudbury
Benjamin B. Towne, Jr., Pittsfield
Kathe L. Washton, Cambridge

Martha M. Eliot, M.D., Honorary President, Massachusetts Fund for Children and Youth, Cambridge, ex officio
Charles Jackson, Jr., President, Massachusetts Fund for Children and Youth, Dover, ex officio
William M. Schmidt, M.D., Chairman, Massachusetts Committee on Children and Youth, Brookline, ex officio

Staff

Lorraine V. Klerman, Dr.P.H., Project Director
Paula Sanofsky, Research Associate
Deborah Solomon, Research Assistant
Paulette Kolodziej, Secretary

PREFACE

The Task Force on Children's Services was created by the Massachusetts Committee on Children and Youth (MCCY) in late summer, 1972 to develop recommendations for the proposed state reorganization of children's services. The needs of children in Massachusetts and the organization of programs for them within state government were not new concerns for MCCY, which had been conducting studies, making recommendations, and undertaking social action on behalf of children since its appointment by the Governor in 1959.

The proposed reorganization of the Executive Branch of the state government, initiated in 1971 and developed in more detail for submission to the legislature in 1973, provided an opportunity for a searching look at services provided to children in the Commonwealth. MCCY wanted to be prepared to discuss the needs of children as a part of government reorganization and to suggest organizational structures capable of meeting these needs. Beyond this, when the reorganization plan was formally delivered to the legislature, MCCY and others concerned about children had to be prepared to press for those portions of the plan which gave promise of benefiting children and to suggest alternative approaches for those portions which seemed not to work in children's interests.

With these two goals in mind, namely in-put into the second phase of state government reorganization and the preparation of a series of long-range recommendations, the Task Force on Children's Services began its deliberations in September, 1972. This report summarizes its deliberations and presents its recommendations.

The MCCY Executive Board considered this report of the Task Force on Children's Services on June 21, 1973. The Board adopted the major recommendations of the report presented in Chapter I. These as well as many other issues and recommendations demand careful consideration by concerned parents, social welfare and other professional groups, and the Executive and Legislative branches of government. We hope it will lead to positive action on behalf of the children of the Commonwealth.

In accepting the report, the MCCY Board expressed its deep appreciation to Chairman Adam Yarmolinsky, Vice Chairman Robert H. Gardiner, and to all the other members of the Task Force for their contribution which made this document possible.

And, finally, we are particularly indebted to the Godfrey M. Hyams Trust and the Mabel Louise Riley Charitable Trust without whose financial assistance the project could not have been undertaken.

William M. Schmidt, M.D.
Chairman,
Massachusetts Committee on
Children and Youth

TABLE OF CONTENTS

Chapter		Page
I.	THE TASK FORCE RECOMMENDS . . .	1
II.	THE COMMONWEALTH'S RESPONSIBILITIES TO ITS CHILDREN	4
III.	THE NEEDS OF CHILDREN ARE NOT BEING MET	8
	Concerned Citizens and Child Specialists Respond	8
	Previous Studies Show	12
	Infant Mortality	12
	Medical Care	13
	Teenage Births	13
	Malnutrition	13
	Foster Care	14
	Child Abuse	15
	Emotionally Disturbed Children	15
	Mentally Ill Children	17
	Runaways and Street Children	17
	Handicapped Children	18
	Delinquent Youth	19
	Gaps in Services	21
	Another Case History	21
	Chart: Services Needed to Implement a Preventive Approach to the Problems of Children and Their Present Availability in Massachusetts	23
IV.	THE NEED FOR AN INTEGRATED AGENCY	31
	Problems with the Current System	31
	Low Priority for Children	31
	Insufficient Attention to Prevention	32
	Labeling of Children	32
	Functional Duplication	33
	Lack of Accountability	33
	Inability to Plan	33
	Advantages of a Single Agency	33
	An Overview of State Government Categorical Programs	35

Chapter		Page
	Executive Office of Human Services	35
	Mental Health	35
	Public Health	36
	Public Welfare	37
	Youth Services	39
	Office for Children	40
	Executive Office of Educational Affairs	40
	Executive Office of Communities and Development	41
	Executive Office of Manpower Affairs	41
	Governor's Committee on Law Enforcement and the Administration of Criminal Justice	42
	Other Programs	43
V.	A PREVENTIVE APPROACH TO THE PROBLEMS OF CHILDREN	46
	Developing a Healthy Environment	46
	Poverty	47
	Racism	47
	Services and Facilities	48
	Essential Programs	49
	Prevention of Problems	50
	Early Detection	51
	Prompt Treatment	52
	A Non-Categorical Approach	53
VI.	CHILDREN'S SERVICES AGENCIES AT THE AREA LEVEL	55
	Functions	55
	Planning	56
	Delivery of Services	56
	Children's Services Center	57
	Children's Services Workers	58
	Operating Procedures	59
	Physical Facilities	60
	Information and Referral	60

Chapter		Page
	Service Registry	60
	Program Monitoring	61
	Organization	62
	Council Selection	62
	Budgeting	62
	Staff Recruitment	63
	Controls	63
	The Choice of Strategies	63
VII.	A NEW STATE AGENCY FOR CHILDREN	66
	Functions	66
	Assistance to Area Agencies	66
	Guidelines	66
	Consultation	66
	Appeals	67
	Staff Development and Training	67
	Budget	67
	State Level Functions	67
	Advocacy	68
	Planning	68
	Monitoring and Evaluation	68
	Licensing	69
	Inter-Agency Coordination	69
	Program Operation	69
	Organization	70
	Position in State Governmental Structure	70
	Checks and Balances	71
VIII.	THE RECOMMENDATIONS IN ACTION	73
	Statement of Dr. Andrew D. Guthrie, Jr. and Mel Shea and Miss Margaret A. Sullivan	75

CHAPTER I

THE TASK FORCE RECOMMENDS . . .

In this report the Task Force on Children's Services of the Massachusetts Committee on Children and Youth presents its analysis of the status of children's services in the Commonwealth and its recommendations for their improvement. Its five major recommendations are summarized in this initial chapter so that later ones can be read within the framework they provide.

A preventive approach should be substituted for the current policy of dealing with problems only after they have reached crisis proportions or irreparable damage has been done. Such an approach would embrace a wide range of policies and services encompassing: 1) changing public priorities to give children a larger share of the state's resources; 2) improving the environment in which children develop which includes assuring adequate income, eliminating racism, and providing sufficient health care, responsive educational programs, and reasonable housing and recreational opportunities; 3) preventing specific problems and disabilities through health services for pregnant women and young children and educational programs for present and future parents; and 4) early detection, prompt treatment, and rehabilitation of those conditions, physical, mental, and emotional, which cannot be prevented.

All programs for children currently scattered throughout the state government should be integrated into a single children's services system. This system would assume responsibility for programs in the fields of child welfare, physical and mental health, deviant behavior, mental retardation, and employment; and for state personnel and facilities serving the needs of children.

The high degree of interaction between various kinds of health and welfare services and educational programs at the state and local level would make it imperative that a strong liaison be developed and maintained between the two systems.

Each area* should have a children's services agency which would supervise all state-supported children's services in the area with emphasis on prevention. Under this proposal, each area would have a Children's Council and a clearly identifiable center for children's services . Each Council would assess local needs and resources and develop additional programs as needed within guidelines developed by a state-level agency. Each Council would determine the mix of direct service and purchase of service appropriate for its area, and would monitor the quality of services delivered under both systems. Children's services workers should follow the problems of individual children and families, and bridge the gap between the various specialists' services.

At the state level as well, a children's services agency should be established which would conduct specialized activities and assist the areas with their duties under state-supervised guidelines. The operation of programs, services, and facilities too specialized for area administration would be a state function, as would advocacy, planning, monitoring, evaluation, licensing, and inter-agency coordination.

---

* Areas should include between 75,000 and 200,000 persons. (See Chapter VI)

Additional funds should be appropriated at the state and federal levels, both to provide adequate services for children and to improve the physical and social environments in which children develop. Although the recommended organizational changes would make the service delivery mechanism more efficient and effective, they will not result in a significant improvement in children's lives unless more money is made available.

Only through the increased expenditure of funds within a coordinated area-state preventive approach, with responsibility pinpointed and services integrated, will children like Joseph Lovoie be saved.

FATAL FIRE IS LAST CHAPTER OF 4-YEAR-OLD'S TRAGIC LIFE

By Jean Caldwell, Globe Correspondent

The Boston Globe, January 13, 1973

SPRINGFIELD - Joseph Lovoie, 4, who died Thursday when fire swept the condemned apartment building where his family lived, appears to have been a born loser.

He would wear the same clothes to school a week at a time.

He would steal food from the other children in his class in Springfield's Head Start program.

A doctor said he was anemic. Teachers thought he suffered from malnutrition.

Last May he came to school with what appeared to be rope burns on his body and his neck.

Perhaps the only good thing in his life was a birthday cake he had at school October 13, his fourth birthday. He couldn't believe it was really his.

Frederick Moore, local director of Head Start, said Joseph Lovoie was "a clear case of child abuse."

So procedures were begun last May to get Joseph out of a home which Moore and his staff were convinced did not give Joseph the "affection, love and attention he needed."

A psychiatrist in the Child Guidance Clinic at Springfield Hospital Medical Center agreed and recommended that Joseph enter the Head Start program.

When Joseph was 2, his mother Lucie Lovoie White, had left him with a babysitter after having been beaten up at an amusement park and hospitalized. Later, while Mrs. White was still in the hospital, the babysitter had to enter the hospital, too, and turned Joseph over to the Division of Child Guardianship.

When Mrs. White was released from the hospital, she tried to get Joseph back. The Division of Child Guardianship refused. Mrs. White obtained help from the Neighborhood Legal Service.

A three-judge Federal panel in Boston ruled that the Division of Child Guardianship had taken the child in violation of the 14th Amendment. Judge Arthur W. Garrity, Jr. ruled: "It cannot be doubted that parenthood is a substantial interest of surpassing value and protected from deprivation without due process of law."

Thursday, Joseph Lovoie was dead. A Springfield fireman wrapped his body in a blanket and carried him from his fire-struck home at 92 Adams Street. Yesterday the Springfield Housing Department disclosed that the apartment into which the Whites recently moved was condemned last August.

Moore said the system moves too slowly for children like Joseph Lovoie. He said Head Start had been working for nine months to try to get the boy removed from the home and that 8 or 10 of the 400 children in the Head Start program have problems similar to those experienced by Joseph Lovoie.

##

CHAPTER II

THE COMMONWEALTH'S RESPONSIBILITIES TO ITS CHILDREN

The Task Force believes that the state government must assume responsibility for ensuring that all children growing up in Massachusetts are provided with the environment and the services necessary for the development of their fullest potential. This statement should not be interpreted as suggesting that state government must provide all services that children need or that the Commonwealth should take an active role in child rearing. The Task Force affirms the primacy of the family in meeting the needs of children. The intent of these recommendations is to improve families' capabilities to meet their responsibilities through supportive services, and to provide assistance in those cases where families do not exist or cannot cope.

The increasing complexity of American society has changed the relationship between parents and children in many ways. Functions formerly performed by the family, such as education, have been assumed by outside agencies. The division of place of employment from place of residence and the increasing employment of women have separated parents from children so that they do not participate in some of the productive activities which formerly brought them together. Advances in medicine and health care have resulted in many children surviving who in previous decades would have died. Some of these children have handicaps that require specialized care beyond the ability or means of most families if they are to continue to survive and to develop their capabilities.

A secondary consequence of our complex society has been the change in household structure. When several generations or collateral relatives still lived in one household, there were many sources from which a child could receive love and care. If a single parent, or even both, was temporarily or permanently absent or inadequate, if a child was born to an unwed mother, or if an infant was born handicapped and needed additional attention, families had the emotional resources necessary to help children survive the strain. The system was elastic. But today almost all children are reared in households consisting solely of children and one or both parents. With little elasticity, small strains cause ruptures, some of which can be mended with the assistance of community agencies.

Thus society has changed, the structure and the functions of the family have changed, and, as a consequence, the responsibility of state government in relation to children must change. In addition to taking action to improve the environment in which the child develops, it must make sure that a wide range of essential services is available to children. A variety of options is open to the state government in meeting this latter responsibility. It can and should assist other public and private agencies which provide services to families and their children, such as schools, hospitals, social agencies, courts, and recreational groups. This assistance can take the form of subsidy, cooperative planning, purchase of service, licensing, and personnel loan. Then there are certain functions which the state government may decide to reserve for itself as the only entity with the power and the capacity to reach every community regardless of its size or degree of isolation, and the only entity with the financial resources to support certain major institutions or specialized services. When new needs are recognized and appropriate services must be provided,

state government must decide whether to provide the service or encourage and assist another agency to do so.

But regardless of how the Commonwealth decides to divide the service functions, it cannot divide the responsibility. The responsibility for assuring that children have access to competent health care, receive an adequate education, and are protected from neglect and abuse, to mention only a few areas, should be given to a single agency of state government. Such an agency would continually study children's needs and evaluate the adequacy and effectiveness of children's services regardless of their source. When needs are not met or when services are inadequate, this agency would be required to take effective action. Although the Commonwealth should encourage families and public and private agencies to serve children to their fullest ability, it must monitor the results. No child's needs should go unmet because a family is unable to provide or an agency has become overburdened.

Obviously there are limits to the Commonwealth's resources. No society could provide every child with every service that potentially could be beneficial. In fact, too many services, involving too much intervention by institutions outside the family can be harmful, even when each individual action could be justified. Also providing such a level of services to children might mean depriving other segments of society, including another frequently dependent population, the elderly. An additional difficulty is that as aspirations are raised, the number of children who potentially require services increases, and manpower and fiscal requirements expand. But children, the segment of society most easily hurt by negative influences, most responsive to a positive environment, and least able to speak for itself will only receive a reasonable share of society's resources, if a vigorous, continuing effort is made to protect their interests.

Society has made great progress in improving the lives of children since the time when they were considered merely the property of their parents. The English Poor Law of 1601 signaled the beginning of organized efforts to assist paupers and orphans. Beginning in the mid-nineteenth century, legislation allowed intervention in the family when children were neglected or abused. More recently, governments have attempted to protect children's rights and to provide them with various services. The first White House Conference in 1909 was a landmark in focusing attention on the needs of children, and resulted in many new state laws and the establishment of the federal Children's Bureau. In 1959 the United Nations General Assembly adopted a Declaration of the Rights of the Child[1] which affirmed:

> the rights of the child to enjoy special protection and to be given opportunities and facilities to enable him to develop in a healthy and normal manner and in conditions of freedom and dignity; to have a name and a nationality from his birth; to enjoy the benefit of social security, including adequate nutrition, housing, recreation, and medical services; to grow up in an atmosphere of affection and security, and wherever possible, in the care and under the responsibility of his parents; to receive special treatment, education, and care if he is handicapped; to be among the first to receive protection and relief in times of disaster; to be protected against all forms of neglect, cruelty, and exploitation; and to be protected from practices which may foster any form of discrimination.

More recently the 1970 White House Conference on Children[2] suggested that children have:

> The right to grow in a society which respects the dignity of life and is free of poverty, discrimination, and other forms of degradation.
> The right to be born and be healthy and wanted through childhood.
> The right to grow up nurtured by affectionate parents.
> The right to be a child during childhood, to have meaningful choices in the process of maturation and development, and to have a meaningful voice in the community.
> The right to be educated to the limits of one's capability and through processes designed to elicit one's full potential.
> The right to societal mechanisms to enforce the foregoing rights.

This philosophy is expressed in the legislation creating the Office for Children,[3] quoted below, but has yet to be implemented in the organization and maintenance of services for children in the Commonwealth.

> It is hereby declared to be the policy of the commonwealth to assure every child a fair and full opportunity to reach his full potential by providing and encouraging services which strengthen family life and support families in their essential function of nurture for a child's physical, social, educational, moral, and spiritual development. Every child shall be entitled to the full protection of the commonwealth. In the absence or inability of parents to provide care and protection for their children, it shall be the responsibility of the commonwealth to assure substitute residential care and protection for every child.

To reestablish the atmosphere that made Massachusetts a leader in children's services requires a new impetus, a new commitment to children, and additional funding as well. The adoption of these recommendations would enable present and future resources to be utilized more effectively to meet children's needs and ensure their rights.

REFERENCES

1 - United Nations Office of Public Information, Summary of Declaration, September, 1968.

2 - White House Conference on Children 1970, "The Rights of Children," Report of Forum in Report to the President, U.S. Government Printing Office, 1971. For a critical analysis of this report read Richard J. Gould, "Children's Rights: More Liberal Games," Social Policy, 2, July-August 1971, 50-52.

3 - Commonwealth of Massachusetts, Chapter 785, 1972, An Act Establishing an Office for Children and Centralizing the Licensing, Regulation, Placement and Monitoring of Day Care, Foster Care and Group Care Services, Centers and Facilities.

CHAPTER III

THE NEEDS OF CHILDREN ARE NOT BEING MET

The Task Force has asserted that the needs of children in Massachusetts are not being adequately met. While many who serve children in need on a daily basis--social workers, physicians, judges, and others--find the evidence so convincing that documentation seems unnecessary, the leaders of state government and the citizens of the Commonwealth should be provided with a systematic appraisal of the gap between needs and services.

The Task Force chose not to do a survey of unmet needs in the Commonwealth - such surveys had been done before[1] (and will be reviewed in this Chapter) and a new one would have delayed the preparation of its recommendations. Instead, it went directly for evidence to those who work with children and to past reports.

Concerned Citizens and Child Specialists Respond

Over fifty individuals and groups responded to the Task Force's request for their evaluation of the most critical issues and problems affecting children's services, and for the changes required if children's needs were to be met effectively. The range of subjects raised and the depth of concern expressed are suggested in the following excerpts from their comments.

A central issue is the destructive environment in which children are forced to grow up and the need to create more opportunities for inner-city children. Every day we at Dorchester House see bright 8 and 10-year olds and the tragedy is that one knows that by the time they reach the age of 14 in that devastating environment, some are going to be dropouts, heavy drinkers, into drugs, on the way to jail, on welfare, or otherwise dependent on society.

(James A. Hooley, Executive Director,
Dorchester House, Boston)

The most crucial issue is the lack of services to support a family's healthy functioning. Parents who are beaten down and overwhelmed with reality and emotional problems produce problem children, therefore, services must focus on their needs as well as children's needs. Specifically, there is a need for supportive and educational services to be available to the total family unit beginning with the prenatal stage. A concerted effort should be made to reach higher-risk families... There needs to be a recognition that helping adult family members during periods of stress or crisis can be crucial in preventing long-term difficulties affecting the entire family. Since children have no lobby, most funding finds its way into the area of adult services.

(Ophie A. Franklin, Executive Director,
The Putnam Children's Center, Boston)

If a child "loses out" before he is five, he is a loser for the rest of his life. Opportunity for children in housing, health, employment, education, etc. should be programmed into state structure.

(John R. McGaughey, former Director of Research and Planning, Massachusetts Department of Public Welfare)

Agencies usually have no way of protecting the abused child until it becomes the broken and battered child.

(Edward Domit, Executive Director, Elizabeth Peabody House, Somerville)

Once the child becomes broken and battered and thereby eligible for intervention, no suitable foster home care services are available.

(Walter J. Kelliher, Mayor, Malden)

Three urgent needs are:

to provide for children who are in the uncovered caseload of the Division of Family and Children's Services within the Massachusetts Department of Public Welfare;

for further strengthening of supports to troubled families, which would include expansion of day care, homemaker, group and foster care services; and

to develop adequate preventive and protective services.

(Child Welfare League Member Agencies)

Lack of sufficient emphasis on planning for the needs (e.g., day care) of female-headed families which contain the greatest proportion of children with special needs.

(Lawrence Kotin, Executive Director, Cambridge and Somerville Legal Services, Inc.)

Accountability has to be built in so that workers will discontinue placing children when they know ahead of time the placement will fail.

(Mary G. Devlin, Founder, Massachusetts Foster Parents Association)

Children being placed in temporary setting after temporary setting with no one making a permanent commitment to the child.

(Robert A. Fazzi, Executive Director, Center for the Study of Institutional Alternatives)

You talk about child neglect? The Department of Public Welfare is the Number One offender. We're not doing social casework. We don't do counselling. We're firemen. We go from emergency to emergency . . working on survival issues. This is emotional work and our workers burn out fast.

(Child Welfare Supervisor, Massachusetts Department of Public Welfare)

...children with special needs being "referred" from the Department of Mental Health to the Department of Education and back until they are no longer children and no longer can be helped.

(William M. Craft, Chairman, Department of Human Resources, North Shore Community College, Beverly)

We need to be able to care for the health needs of young people who are not covered through Medicaid for one reason or another, and who cannot afford medical care.

(Marian B. Katzenstein, State Coordinator, Women in Community Service, Inc.)

Our primary concern is the fragmentation and lack of delivery of services to the troubled adolescent. One of the major problems facing the Commonwealth is the dearth of residential treatment centers for acting-out adolescents. In our work with these youngsters in a community-based program, we have come to accept the fact that a small but significant minority of youngsters cannot tolerate the open nature of the community and need therapeutic treatment within a confined structure. Be assured, we are not talking about institutions like Lancaster and Lyman that locked up youngsters and called it "therapy" but rather, settings which set firm controls and enforce limits, yet provide excellent therapeutic intervention in the lives of the youngsters and their families. More such places are needed that would provide living facilities as well as competent therapy by trained professionals.

(Louise E. Homer, Assistant Executive Director, Youth Opportunities Unlimited, Inc. (Intensive Probation Service))

There is a very serious lack of services for young people in the 12-21 year age group at the present time. These youngsters are not adequately cared for either by public or private agencies in the state. Most agencies are not looking at their needs, attempting to meet them, or looking into the reasons why they have the problems they do.

(Monsignor Eugene P. McNamara, Executive Director, Catholic Charitable Bureau of Boston)

In so many cases the young people with whom I deal either have one or no parent to turn to for support. Their education in life comes from the street and their support from their peers. I feel that the social services have to pick up the slack when the parents can no longer cope.

This can best be done by redirecting our priorities from those of treatment to those of prevention.

(Thomas S. Bennett, Director, Island Youth Center, Martha's Vineyard)

We must reverse the present trend of spending the majority of our child welfare funds for corrective services to children outside of their own homes rather than investing substantial amounts of money into preventive efforts which would enable parents to provide adequate care for their children.

Recent studies have documented that it is not only better for the child and his parents, but it is much less costly to the taxpayer. See, for example, Dollars and Cents in the Foster Care of Children, A Look at Cost Factors published in 1972 by the Child Welfare League of America for interesting documentation. [2]

(Robert M. Mulford, General Secretary, Children's Protective Services of the Massachusetts Society for the Prevention of Cruelty to Children.)

Unemployment is a critical problem. The lack of satisfying opportunities to work is very destructive to young people and contributes to development of destructive alternatives.

(William M. Schmidt, M.D., Head, Department of Maternal and Child Health, Harvard School of Public Health)

...lack of educational support for children excluded from school or in need of special schooling.

(Richard Robbins, Professor of Sociology, University of Massachusetts, Boston)

The majority of children in need of services does not receive such services because they do not fall under the jurisdiction of the resource agencies available, such as Division of Youth Services, Neighborhood Youth Corps, Division of Child Guardianship, etc. The problem is compounded by school departments unwilling to quantify or even make known the extent of their drop-out rate. The problem is one of shifting emphasis from treatment of juvenile delinquency to prevention.

(Rev. James J. Bretta, Administrative Assistant to Somerville Mayor)

The lack of coordination and fragmentation of services among the public agencies serving children has a negative, sometimes fatal effect on the life of a child. Often when a child needs placement, he is caught between the Department of Public Welfare, the Department of Youth Services, and the Department of Mental Health, with the tragic result that the child gets lost and is not served. There is a lack of cooperation and coordination among existing agencies which are supposed to serve the same children.

(Arthur Z. Mutter, M.D., Director, Children's Services, Tufts Community Mental Health Unit)

The faulty delivery system lacks responsiveness to individual needs of children, commitment to preventive intervention, and accountability to the community.

(Patrick V. Riley, Executive Director, Family Service Association of Greater Boston)

The multi-layered network of specialized and autonomous agencies yields fragmented, overlapping, inefficient and unresponsive service delivery. The proliferation of special or single-purpose social, educational, and health-related service programs, generally administered through separate state agencies and, in turn, through their separate local affiliates results in too much scattering of resources, too little coordination, and minimal consolidation.

Under our present structure, each of our services works diligently perhaps, but in its own corner. Child Welfare sits in one corner and youth services in another. Here are the child guidance clinics and there are the schools. Welfare may be holding the family together with some assorted economic supports, yet the youth director down at the "Y" may think he knows the youngster better than anybody, except for the out-reach worker of the local drug center, who has yet another whole perspective. Ironically, after repeated breakdowns, it is oft times the probation officer who finds himself in the belated position of tying all parts together--a coordinator of sorts to evolve a plan of treatment instead of the plan of prevention which the community should have tried much earlier.

(Ruth S. Tefferteller, Associate Area Director, Human Services for Children and Youth, Inc., Region IV)

The major problem concerning children's services is the lack of commitment by the government to truly adequately finance children's services. We prefer to put money into roads and buildings rather than to the non-visible children's agencies.

(John E. McManus, Executive Director, New Bedford Child and Family Services)

Previous Studies Show

The failure of the Commonwealth to meet the needs of children has been documented systematically in a series of recent studies. Although lacking the vividness of case histories, they provide a more complete picture of the magnitude of some of the problems.

Infant Mortality

Boston in 1970 had an infant mortality rate of 21.7 per 1,000 live births, well in excess of the state rate of 17.3. The statistics are even more distressing for some of Boston's poverty areas: in the total Model City area 47 infants died before their first birthday, an infant mortality rate of 33.8 per 1,000 live births, and in some of the individual Model City areas the rate was in excess of 40.[3] These figures undoubtedly could be duplicated in other poverty areas of the Commonwealth. In fact, almost all of the counties housing major Massachusetts cities were listed

in the 1968 Children's Bureau report[4] of the 290 counties in the nation with the highest number of "excess infant deaths" (defined as those in excess of 17.8 per 1,000 live births - a rate which 10% of the counties in the United States already had achieved or bettered), in the 1961-1965 period.

County	Major City	Infant Deaths in Excess of 17.8 per 1,000 in the 1961-1965 Period
Suffolk	Boston	427
Middlesex	Cambridge	329
Worcester	Worcester	271
Essex	Lynn	195
Bristol	New Bedford	142
Norfolk	Quincy	127
Hampden	Springfield	123
Plymouth	Brockton	101

Medical Care

The inadequacy of health care was pointed out in a 1968 MCCY report[5] which disclosed that in the Berkshire area:

> more than 50 percent of AFDC preschool children had never been seen by a physician. Also, none of these children was known to the well-baby clinics.
>
> Mothers and children, who made up about 60 percent of the population of these towns, for all practical purposes received no nursing services . . .
>
> The pediatric clinics and the well-child clinics were poorly attended and there was no follow-up of families involved. Also, no community or home nursing services were provided at the prenatal clinic.

Using Somerville as an example, the report showed that an equally critical shortage of health services existed in metropolitan areas, but a 1972 report indicated substantial improvement in that city.[6]

Teenage Births

Births to girls 17 and under have been shown to carry a high risk both to mothers and infants: Despite this fact, in Boston, the number of mothers in this age group increased from 509 in 1969, to 586 in 1971. Forty-six of the births in 1971 were to girls under 15.[7]

Malnutrition

Seven day-long diet clinics were run in different sections of Boston by several welfare rights and health organizations during the Summer and Fall of 1970. They served over 800 welfare recipients and found that 32% of 247 children between 6 months and 6 years of age and 41% of 275 adult women, mostly of childbearing age, were anemic; and that 45 of 469 children under age 12 fell below the 25th percentile on standard growth and development charts, evidence of impaired growth.

The sponsoring agencies concluded that "a substantial proportion of the people on welfare were maintaining themselves on a diet that was inadequate for their nutritional needs and that malnutrition exists on a wide scale among welfare recipients in Boston."[8]

Foster Care

Additional documentation of inadequacies can be found in the reports of several state commissions, most recently one which studied foster home care.[9] Based on an analysis of 5,862 children in foster home care as of November 18, 1971, the Governor's Commission concluded that far fewer children would have had to be placed if parents had been able to obtain services such as day care, counseling, or homemakers. Sixty percent of the families were in contact with the foster care agency two weeks or less before the child was removed from home. Other findings include:

Despite the temporary purpose of foster home care, it is more often than not a permanent status for the child.

- about 68% of the children have been in foster home care between 4 and 8 years

- 83% of the children have never been returned to their parents, even for trial periods

Children in the care of the Division of Family and Children's Services do not receive adequate diagnostic and/or treatment services.

- almost 40% of the children have one or more disabilities

- 25% of the disabilities have never been evaluated

- over one quarter of those who have been evaluated have not had the recommended treatment program implemented

The procedures of the Division of Family and Children's Services have permitted seventy percent of the parents to maintain parental rights without demonstrating significant interest in their children.

- 70% of the parents have not seen their child for six months or more

The Division does not move effectively to free children for adoption.

- in 40% of the cases where social workers have determined that adoption is appropriate, no steps have been taken to legally free them

The Division does little to prepare or support foster parents.

- 20% of the foster homes are over-crowded according to the Division's own standards (more than 6 children under 16 years of age)

- 12% of the foster parents never even talked to the social worker before the child was placed

- less than one quarter of the foster parents received any training prior to receiving their first foster child.

The Division has no effective administrative tools to identify the needs of children in their care or to effectively report the nature of its activities.

- 70% of the children are either uncovered or have been in a social worker's caseload less than one year

- children without social workers remain in care longer and are less likely to be adopted.

Child Abuse

The Governor's Committee on Child Abuse in its 1971 report[10] was able to document over 900 cases of abuse and almost 4,000 cases of neglect in Massachusetts in 1970. It estimated that the actual number of such children was 7,290. The Commission noted:

> The causes of child abuse are multiple and a variety of resources and services must be available to identify and treat the family crises which result in harm to the children. They must view the identification, referral, and treatment of these situations as a top priority which requires immediate response and the commitment of highly skilled staff. A mechanism for coordination between the departments and agencies responsible for these varied services is mandatory in order to make this model of services a reality. Only by ensuring that families receive the help they need when they need it can we begin to push back the rising tide.

A private agency also underscored the dimensions of the problem. In 1971 the Massachusetts Society for the Prevention of Cruelty to Children reported:[11]

> Children's Protective Services in 1970 served over 8,800 children and in doing so was able to serve only one out of three referrals on a continuing basis. The expenditure of $1,279,000 resulted in a $330,000 operating deficit and we, like the public programs, were only scratching the surface of need.

Emotionally Disturbed Children

Another program which has received much criticism from official and private sources is the so-called "750 Program" under which the Departments of Mental Health and Education share responsibility for assisting localities in securing education for emotionally disturbed children. State law requires each school district to provide for the education of these children either in classes in regular public schools or through the use of home tutors, but it allows communities to send such children to private residential and day schools within or outside the Commonwealth. The Massachusetts Advisory Council on Education in 1971[12] stated:

In Massachusetts, Chapter 750 has become a problem of major proportions. In a program whose initial state allocation of $1,000,000 is now approximately ten times that amount, just a few years later, the waiting lists of eligible children expand as local communities increasingly resist pressures to inaugurate community based, publicly supported curricula for the handicapped. And, as disturbed children are sent to private schools under the provisions of Chapter 750 -- rather than to community public school programs -- they appear to remain there years longer than originally thought necessary. In the meantime, boards of education and their constituencies continue to neglect developing facilities and programs that might have permitted those children to remain at home, in a normal community environment. In effect, what was originally intended to be positive and liberal legislation on behalf of handicapped children may have become the instrument that now prevents, or discourages, local communities from meeting their obvious responsibilities to these children and their families.

A recent report of the Department of Mental Health[13] shows that progress has been made, but the size of the waiting list indicates that by year's end one child in six is not receiving the care for which he was referred.

Disposition of Children Referred for Care Under Chapter 750 as of December 31, 1972
(Table adapted from Department Report)

Special Class	1,416
Integrated	1,158
Private Residential	1,043
Private Day	655
Home Instruction	463
Discharged	263
Pending (Waiting List)	995

The following observations on the "750 Program" are from a study prepared for the Senate Ways and Means Committee:[14]

During the approximately ten years of operation of the program the Department of Education seemingly has chosen a rather passive role in carrying out this legislation. Due to a combination of things, mostly lack of direction on the part of both the Commissioners of Education and the Board of Education, the Bureau of Special Education has elected to go the easiest route using the authorization under the permissive section to relieve public school systems of their emotionally disturbed children by placing them in private schools.

There are no written or even understood criteria for evaluation of the thirty-three residential and twenty private day schools used other than standard health and safety requirements for building occupancy and even those are not scrutinized.

Each school used by the department is allotted a "quota" of children, but no one at the department was able to really explain how quotas are assigned. They did say that the quota assigned a school has nothing to do with its quality.

There is no effort by the bureau to take on the task of doing any evaluation of the schools and their effectiveness with Massachusetts students.

In January, 1970 the bureau developed and disseminated some guidelines for use by public schools in establishing and running programs at the local and regional level, but nothing has been done since then to get the communities to use them or to comply with Chapter 71 responsibilities in this area.

Local school people are highly critical of the Department of Education for the lack of leadership in this area and for the bureau's either unwillingness or inability to help local school people by giving them consistent and specific information in the area of education for the emotionally disturbed.

Legislators have interfered with the placement of children and efforts to weed out "bad" schools and the extent of that interference seems to have sapped what little reform spirit existed in those administering the program.

Mentally Ill Children

A critical shortage exists in publicly-supported inpatient facilities for mentally ill children. The Task Force on Children and Youth of the Massachusetts Mental Hospital Planning Project[15] found:

> ...only one major psychiatric program in Massachusetts providing total care facilities for children under 16 years of age. There is only one program which specifically addresses the developmental needs of adolescents who are in need of hospitalization.

Runaways and Street Children

The needs of some groups of children are less recognized, and, therefore, more underserviced than others. Runaways and street children, for example, were cited in a 1971 MCCY report.[16]

> Approximately 1,000 each year turn up in the District and Juvenile Courts of the Commonwealth. All but 13% of these live in Massachusetts. It is quite apparent that the children appearing in court represent only a small proportion of the total number...Estimates of the number of children on the streets of Boston last summer ran as high as 50,000. The incidence of various physical and psychological disorders was very high.

A subsequent study,[17] based on reports from 117 cooperating agencies, identified 428 children who had run away during a single month, July, 1972. These children ranged in age from six to seventeen, but over half were fifteen and under. During the same month 71% of the 92 runaway

children arrested in the Commonwealth were fifteen and under. Furthermore, as the report went to press, it was learned that in February 1973, Massachusetts had experienced another escalation in the number of runaway and street children and that more than half of them were only eleven and twelve years old.

The report pointed out the valuable role being played by "hot lines", emergency shelter services, youth service centers, and certain medical facilities and urged the extension of these services in areas not currently served. It commended the Division of Drug Rehabilitation of the Department of Mental Health and the Department of Youth Services for providing certain financial assistance to agencies helping runaways and street children, but added:

> ...the State Department of Public Welfare's Division of Family and Children's Services (formerly the Division of Child Guardianship) was invariably singled out. . . as having consistently failed to fulfill its mandated responsibility to provide care and protection for neglected, abandoned, and physically abused adolescent children. It is a fact that the Division has been understaffed and underfunded for years.

Handicapped Children

Another vulnerable group is those children with single and multiple handicaps. MDCY's 1970 report[18] stated:

> The Crippled Children's Program of the Massachusetts Department of Public Health currently provides health services for only 3 percent of the chronically ill children (approximately 6500 children each year) and almost all of these receive strictly categoric services aimed at treatment of one type of defect. For instance, although one-quarter of the children in the Crippled Children's Program are multiply handicapped, only 3 percent of them are referred from one specialty clinic to another. Another 3 percent of the State's handicapped children are cared for in the State Schools for the retarded, which employ few specialists in the medical care of the physically handicapped. This is the case even though over fifty percent of these children are physically as well as mentally handicapped. It is apparent that the effort made by the Commonwealth of Massachusetts is only a token one which relies heavily on the inadequate funds available through the Federal Crippled Children's Program. For those few children who gain access to the State's program there is high quality specialty care available. For the rest--ninety-seven percent of the handicapped children--no public responsibility is assumed or even contemplated.

The Department of Public Health's Intake, Information and Referral Center for Services to Handicapped Children[19] identified additional problems in providing services to multiply handicapped children, "One of the major gaps is that of skilled nursing care for children (especially 0-6 years of age) in residential facilities. ...There is an active list of approximately 150 children for whom requests have been made during the year for residential placement."

Delinquent Youth

A recent report of the Department of Youth Services[20] (DYS) was critical of the present system:

> The children referred or committed to DYS by the Courts overwhelmingly are from socially and economically handicapped families who generally do not connect with or benefit from community based helping resources and services, for one or more of the following reasons:...
>
> A. Inadequacy of service delivery system
>
> (1) Existing services cannot offer comprehensive treatment for all the child's needs.
>
> (2) Existing services cannot offer continuity of treatment .
>
> (3) Most agencies that deal with children do not offer concurrent treatment of the child's parents and siblings, often the major factor in the child's emotional problems.
>
> (4) The referral network is inefficient, ineffectual, and frustrating to the client. Less than one case in four actually shows follow up on suggested referrals.
>
> B. Lack of sufficient trained manpower
>
> (1) Emotionally disturbed children are more often treated by non-professionals than by professionals.
>
> (2) Public agencies are constrained by Civil Service hiring requirements, which do not necessarily select those staff with the greatest amount of specialized training and field experience.
>
> C. Inappropriate focus of services
>
> (1) Agencies are hierarchical in their acceptance regulations. Criteria for acceptance depend upon the individual's social class, place of residence, and ethnic background.
>
> (2) Public agencies are forced to accept all those clients who do not meet the entrance requirements of the private agencies.
>
> D. Scarcity of resources
>
> (1) Residential placements for adolescents and emotionally disturbed children are scarce.
>
> (2) Public agencies are vastly over-utilized.

E. High cost of care related to client resources

(1) Professional care in a private agency is too costly for the majority of clients, and non-professional service cannot offer equivalent treatment.

F. Inappropriate location of services

(1) Services for children are located outside the urban core where the greatest number of emotionally ill children reside.

G. Poor internal organization and functioning of services

(1) Among the public agencies, staff time is severely compromised. (It has been estimated that only 20-25% of staff time is devoted to direct patient care.)

(2) Professionals who work with public agencies cannot devote full time to this job. Their time is constrained by administrative duties and private practices.

H. Lack of coordination and cooperation between service systems

(1) For example, it has been charged that the Department of Mental Health and the Department of Education do not cooperate effectively in their treatment of children.

(2) Among public agencies, responsibility for service delivery has not been clearly delegated.

I. Lack of sufficient funding for public agencies

J. Inappropriate allocation of public agency budgets to meet the needs of children.

(1) For example, the Department of Mental Health spends only 15% of its total budget on children. Of this amount, most is spent on residential care for retarded children.

K. Lack of public education of the needs of emotionally disturbed children and the services which are available.

L. Inability of clients to protect their rights

(1) The individual has no means of recourse against an agency which chooses not to treat him or which offers him treatment he believes to be inappropriate other than legal action, which is a lengthy and costly process.

Gaps in Services

While the reports point primarily to the poor quality and inadequacy of current services, a chart prepared by the Task Force corroborates the problem identified in many of the expert responses: the total absence of vital services, some of which are mandated by law for the care and protection of children, and the limited availability of others. Using as a framework the preventive approach which will be elaborated upon in Chapter V, the Task Force attempted to determine whether any agency in the public or private sector was providing the services it felt should be available to children and youth throughout the Commonwealth. The chart which follows the case history below shows how poorly Massachusetts is meeting the service needs of children.

Another Case History

THE FUNERAL HAD TO BE SOMEWHERE

by

Anthony Pearson and Ken O. Botwright, Globe Staff
The Boston Globe, March 31, 1973

BEVERLY -- Services for a 13-year-old ward of the state shot by Lexington Police during a car chase were held here yesterday because, as one social worker put it, "he never really had a home and the funeral had to be somewhere."

Loren's natural parents, Loren and Ann Haskell, from whom he was taken 10 years ago, were not among the mourners, and the state Child Guardianship Division yesterday still wasn't sure "whether they even know the boy is dead."

"We don't know how to reach his parents or even where they're living," state social worker Dean Carter of Beverly said, as Loren's plain steel casket was wheeled into St. Mary's Church. "A death notice was placed in the newspapers, but so far they haven't contacted us or the Campbell Funeral Home in Beverly."

Another social worker at the church predicted: "It may be weeks, even months, before we reach the boy's parents. In fact, there's a chance they'll never know their son is dead."

Somehow, that din't seem to matter much because Loren Haskell, taken from his parents by the court at age 3, never knew his natural mother and father. He was one of six children, but he knew only his 16-year-old sister, who is a mental patient.

Loren's foster parents from Burlington, with whom he had lived for 10 years, were visibly shaken and his foster mother wept as she left the church. A young girl also wept, but for most of the mourners, the service was a perfunctory affair, something that had to be done.

Pam Bush, an official of the Welfare Dept., yesterday said a preliminary review of Loren's case points up that the state lacks adequate facilities for "treatment of 13-year-olds with severe emotional and psychological problems." There are hospitals for younger children and older people, but nothing for kids Loren's age.

"He ran away from treatment centers a number of times in the past few months," Miss Bush said. "Police picked him up as a runaway in Dorchester on March 21. We couldn't leave him with the court, but knew we couldn't put him back in a treatment center. So we decided to put him temporarily in a Methuen foster home until we could put him in a hospital."

Loren had been with Mrs. Diodati just three days when he took her car and drove to the end of his short, unhappy life.

##

Although this report could continue to document inadequacies, case by case, statistic by statistic, and statement by statement, the evidence already seems overwhelming. What is needed is not further facts about the problems, but a new approach to their solution -- and that is what the Task Force is recommending.

Services Needed to Implement a Preventive Approach to the Problems of Children and Their Present Availability in Massachusetts*

Services	Current Source of Services**						
	Public Sector						Private Sector
	State Government				Other State or Federal Source	Local Government	
	Executive Office of Human Services***						
	Dept. of Mental Health	Dept. of Public Health	Dept. of Public Welfare	Dept. of Youth Service			
I. Prevention of problems by:							
A. Promoting health of pregnant women							
1. Prenatal care		assistance and consultation	Medicaid		MIC Projects, NHCs		OPDs, MDs
2. Outreach services to locate and encourage pregnant women to seek care (including pregnant addicts)					Boston Child Advocacy Project, MIC Projects, NHCs	HD nurses	VNA nurses, agencies
B. Assuring that only "wanted children" are born							
1. Family life education directed at children and youth			services purchased		consultation from Dept. of Education	Public Schools?	agencies
2. Family planning facilities		assistance and consultation	referral thru local welfare office		MIC Projects, NHCs, also assistance from DCA		OPDs, MDs, Planned Parenthood facilities

*A key to the abbreviations used can be found on the page following this chart.

**The mention in a box of a source of service does not mean that this service is available uniformly throughout the Commonwealth. Many of the services have a very limited distribution.

***Services being provided under the Project for Children, described in Chapter IV, are not included in this chart.

Services	Public Sector						Private Sector
	State Government				Other State or Fed. Source	Local Government	
	EOHS-DMH	EOHS-DPH	EOHS-DFW	EOHS-DYS			
C. Preventing illness 1. Immunization		assistance and consultation	Medicaid		MIC, C&Y Projects, NHCs	HD clinics	OPDs, VNAs, MDs
D. Educating parents to physical and emotional needs of children 1. Counseling in home by outreach workers					MIC, C&Y Projects, NHCs	HD nurses	agencies
2. Classes in neighborhood centers					NHCs		hospitals, VNAs, agencies
E. Placing children expeditiously 1. Adoption			placement				agencies
F. Optimizing child's development 1. Day Care	licensing?	licensing?	licensing?		licensing by Office for Children, assistance from DCA		agencies, private facilities
G. Educating those who come in contact with children in their work	CMHCs, MHC-Cs	courses sponsored with Dept. of Education			Dept. of Education courses		
II. Early detection of problems by: A. Assessing periodically the physical and emotional health of children and the emotional climate of the home							
1. Physical exams including developmental assessment		consultation to schools	Medicaid		MIC, C&Y Projects, NHCs	school exams, HD clinics	OPDs, MDs
2. Home visits to high risk homes by outreach workers					NHCs, MIC, C&Y Projects	HD nurses	VNAs, agencies
B. Maintaining communication with agencies and individuals who might detect early signs of problems including system of followup			protective services				

Services	Public Sector: State Government: EOHS-DMH	EOHS-DPH	EOHS-DPW	EOHS-DYS	Other State or Fed. source	Local Govt.	Private Sector
III. Prompt treatment of problems in order to limit consequences by:							
A. Maintaining information and referral services	CMHC's MHC-Cs	for handicapped	CSCs		Youth Resource Bureaus		community Councils
B. Providing medical care - 1. to acutely ill & injured-in-patient, out-patient, emergency			Medicaid		MIC, C&Y Projects, NHCs	municipal hospitals and clinics	OPDs, MDs, hospitals
2. to chronically ill and handicapped with periodical re-evaluation in-patient and out-patient		Handicapped Children Services Hospital School other public health hospitals	Medicaid		MIC, C&Y Projects, NHCs	municipal hospitals and clinics	OPDs, MDs, hospitals
C. Providing psychiatric &psychological care & casework & counseling for 1. mentally & emotionally ill children	CMHC's, MHC-Cs, state hospitals &schools		Medicaid		Services purchased thru 750	school guidance counseling	Agencies, clinics, MDs, hospitals
2. drug dependent and addicted	detoxification centers, drug clinics, suppo of other facilities						many types of facilities - mostly with support by Dept. or Mental Health

Services	Public Sector						Private Sector
	State Government				Other State or Fed. Source	Local Govt.	
	EOHS-DMH	EOHS-DPH	EOHS-DPW	EOHS-DYS			
3. delinquent & pre-delinquent	CMHCs, Court Clinics, MHC-Cs		social services for some	direct & purchased services	Youth Resources Bureaus	school guidance counseling	agencies
4. teenage parents	MHC-Cs	assistance and consultation	social services				agencies
5. others							
D. Providing supplemental or supportive services to parents to help keep children in own homes							
1. psychiatric & psychological care & casework & counseling for parents of children with special needs	CMHCs MHC-Cs drug clinics		social services, protective services (direct & purchased)	direct & purchased services	Youth Resources Bureaus		MSPCC, Family Service and other agencies
2. Therapeutic day care for those with special needs	licensing ?	licensing ? for handicapped	licensing?, services purchased		licensing by Office for Children		agencies, private facilities
3. Home visits by nurses and others to provide direct care or supervision or support		for handicapped children					VNAs
4. Homemaker services			services purchased				
E. Legal services to parents and children			CSCs	direct services	Model Cities, other programs		gencies gencies

Services	Public Sector						Private Sector
	State Government				Other State or Federal Source	Local Government	
	EOHS-DMH	EOHS-DPH	EOHS-DPW	EOHS-DYS			
F. Alternative living arrangements - temporary or permanent							
1. Foster homes for normal or those with special needs			services purchased -developing and placing	services purchased -developing and placing	licensing by Office for Children		services purchased
2. Group homes for normal or those with special needs		licensing?	services purchased -developing and placing	services purchased -developing and placing	licensing by Office for Children		services purchased
3. Adoptive homes			placement				agencies
4. Small residential units, halfway houses, partial hospitalization, hostels, etc. for mentally ill, retarded, delinquents, drug abusers, etc.	CMHCs, other facilities	licensing?		funding, developing and placing	licensing by Office for Children, purchased thru 750		services purchased
5. Short-stay centers including secure arrangements and emergency shelters			protective services	detention/ shelter care facilities			
G. Special school, educational programs, and sheltered work experiences for children and youth with special needs	CMHCs, nursery schools, state hospitals and schools, rehabilitation centers	for handicapped	services purchased	services purchased -developing and placing	Rehabilitation Administration	public schools-special ed. and 750 programs	agencies and private institutions

Key to Abbreviations in Chart

CMHC = community mental health center

CSC = comprehensive service center

C&Y = children and youth project

DCA = Department of Community Affairs

DMH = Department of Mental Health

DPH = Department of Public Health

DPW = Department of Public Welfare

DYS = Department of Youth Service

EOHS = Executive Office of Human Services

HD = local health department

MD = private physician

MHC-C = mental health clinic serving children

MIC = maternity and infant care project

MSPCC = Massachusetts Society for Prevention of Cruelty to Children

NHC = neighborhood health center

OPD = hospital out-patient department

VNA = visiting nurse association

REFERENCES

1 - For a comprehensive review of issues and problems, read Massachusetts Committee on Children and Youth, Report of the Massachusetts Committee on Children and Youth for the White House Conferences 1970, December 1970.

2 - David Fanshel and Eugene Shinn, Dollars and Cents in the Foster Care of Children, a Look at Cost Factors, Child Welfare League of America, 1972.

3 - Boston data from Boston Model City Administration, Profile of the Model City Area, 1972, April, 1972. Massachusetts figure is based on provisional data provided by the Commonwealth and printed in "Statistical Survey Infant Birth and Death Data," MCH Exchange, II, December 1972, 5-7.

4 - U.S. Children's Bureau, Infant and Prenatal Mortality Rates by Age and Color; U.S., Each State and County, 1956-60, 1961-65, 1968.

5 - John E. Jacobi, Meeting the Needs of Children and Youth in Massachusetts Communities, Massachusetts Committee on Children and Youth, 1968.

6 - Leo F. Friel, Action in Somerville: A Follow-Up Report on the MCCY Local Area Project in Somerville, Massachusetts Committee on Children and Youth, 1972.

7 - Departmental communication from Rowland L. Mindlin, M.D., Director, Maternal and Child Health, Boston Department of Health and Hospitals, September 29, 1972.

8 - Letter to the Editor, Social Policy, 2, November-December 1971, 66-67 signed Gerald Friedland, M.D., Mary E. Mahoney Family Life Centers, Mrs. Margaret McConnell, Senior Nutritionist, Beth Israel Hospital, and Boston Chapter, Medical Committee for Human Rights.

9 - Alan R. Gruber, Foster Home Care in Massachusetts: A Study of Foster Children - Their Biological and Foster Parents, Governor's Commission on Adoption and Foster Care, Commonwealth of Massachusetts, 1973.

10 - Governor's Committee on Child Abuse, Final Report, Commonwealth of Massachusetts, 10-6-71.

11 - Robert M. Mulford, Children, Our Commonwealth's Forgotten and Disadvantaged Minority, paper presented at Joint meeting of Boards of Directors and District Executives, Massachusetts Children's Protective Services of the Massachusetts Society for the Prevention of Cruelty to Children, June 3, 1971.

12 - Burton Blatt and Frank Garfunkel, Massachusetts Study of Educational Opportunities for Handicapped and Disadvantaged Children, Massachusetts Advisory Council on Education, January, 1971.

13 - Department of Mental Health, Distribution of Chapter 750 Children by Region and Area, Type of Disposition, and Disposition Pending as of December 31, 1972, Commonwealth of Massachusetts, February 5, 1973.

14 - Mary Anne Magiera, An Analysis of the Massachusetts Program for Emotionally Disturbed Children, (undated)

15 - Massachusetts Mental Hospital Planning Project, Summary Report, Task Force on Children and Youth, 2/21/73

The facility for children under 16 is the Gaebler Unit at Metropolitan State Hospital. Boston State Hospital has the adolescent service for children from 14 to 18.

16 - Joint Advisory Committee on Long-Range Planning, Report of MCCY Staff on Major Areas of Concern for Children and Youth-1971, Massachusetts Committee on Children and Youth, August 13, 1971.

17 - Margaret B. Saltonstall, Runaways and Street Children in Massachusetts, Massachusetts Committee on Children and Youth, February, 1973.

18 - Report of the Massachusetts Committee on Children and Youth for the White House Conferencespreviously cited.

19 - Division of Family Health Services, Annual Report, July 1, 1971 - June 30, 1972, Department of Public Health, Commonwealth of Massachusetts.

20 - Department of Youth Services, A Strategy for Youth in Trouble, Commonwealth of Massachusetts, February 25, 1972.

CHAPTER IV

THE NEED FOR AN INTEGRATED AGENCY

The establishment of a single children's services system certainly would enable the Commonwealth to improve its services to children. But the implementation of this Task Force recommendation, by itself, would not solve all the problems of service inadequacy or make it possible for all the needs of children to be met. The appropriation of large amounts of additional funds and the modification of the attitudes and behavior of many individuals are essential to the solution of the service problem. Doing a better job of meeting needs means, in addition, changing society's priorities so that children receive a greater share of its resources, both in terms of finances and attention, and so that the environment in which children are raised is more conducive to their fullest development. The changes the Task Force is recommending, however, would be a first step toward changing priorities, securing additional funds, and ensuring that as such funds became available they would be used to best advantage.

Problems with the Current System

Putting aside temporarily the overwhelming problem of insufficient funds to improve either the environment or the services, many other problems can be found within the current system of delivery of services to children in Massachusetts.

Low Priority for Children

America may consider itself a child-oriented society, but as pointed out by the 1970 White House Conference on Children,[1] "Our national rhetoric notwithstanding, the actual patterns of life in America today are such that children and families all too often come last."

The American Public Health Association (APHA) in a 1972 resolution on Child Health and Public Policy[2] commented:

> It is difficult to determine whether or not the promotion and protection of child health is a major goal of public policy in the United States. However, it is quite evident that such a policy, though voiced from time to time by political leaders, has not in fact been implemented by political and legislative action.

Nor is the situation different in Massachusetts. The Massachusetts Advisory Committee on Education (MACE) in its recent report Child Care in Massachusetts[3] stated, "Children, parents, and families come last in Massachusetts as well."

Although one third of the state's population consists of children and youth under the age of 18, it is painfully obvious that children receive far too little of the Commonwealth's non-educational services and that their share is proportionate neither to their numbers nor their need. For example, the Departments of Mental Health and Public Health have 81%[4] and 51%[5] of their respective budgets tied up in large institutions which

BEST COPY AVAILABLE

primarily serve adults. Although Mental Health has many programs for children who are mentally ill, mentally retarded, and drug dependent, and Public Health assists many handicapped children, the emphasis in both these Departments must, and does follow the budget - and children's services, therefore, are a poor second best.

The situation appears even more unbalanced considering that adult problems are usually more advanced and less susceptible to improvement, and that it is among children and youth that there is the greatest possibility of positive change. It is even more alarming when one considers that children are more vulnerable and less able to protect themselves against positive affronts or deficiencies. Infants and young children are unable to protest when their rights are denied or their bodies abused. Even older children are seldom heard by policymakers when they do complain. Many policy changes have occurred during the last few years only because parents have joined together to fight for the needs of children with specific handicaps. Despite the rhetoric about a child-centered culture, children's needs receive low priority in most state agencies.

Insufficient Attention to Prevention

A review of current programs shows that most state agencies focus their inadequate resources on those children whose needs are most advanced. When the Office for Children recently announced the availability of funds through its Project for Children,[6] it was not proposals for innovative programs to prevent problems which were sought, but rather programs to serve "those children who present immediate and severe problems to their families ... (who) are in danger of being removed from their families and placed in institutions or residential care."

This emphasis on correcting advanced problems rather than preventing them entirely or detecting them while they are minor, follows logically from assigning low priority to children's needs. Agencies with responsibilities for a variety of populations and a limited amount of money serve first the adults who make their needs obvious. Then the severely abused, delinquent, handicapped and retarded children come to their attention. They do not have enough resources left to seek out the children whose problems are still minimal, or to develop programs of prevention. Preventive services must be developed so that early intervention can ensure that high risk cases are discovered early and provided with appropriate care.

Labeling of Children

Currently state programs label children as neglected, delinquent, handicapped, retarded, etc. This means that a child is assigned to the specific agency which handles that problem, and then forgotten by all other agencies. No one looks at the whole child, sees the totality of his needs, or plans a program which would allow all those needs to be met. Each agency looks at one aspect of the child, and while that agency has responsibility for him, no other agency wishes to become involved, because limited resources make it seem more reasonable to provide services to the next child whom no agency has helped, rather than to work with another agency on one of its cases. As a result, frequently only a portion of the child's needs is considered.

The need to label a child in order to obtain assistance for him can, and does have many kinds of short and long term deleterious consequences. Children who are mentally retarded are labeled mentally ill,

and vice versa in order to make them eligible for certain services. Also, labels, like delinquent and retarded, are difficult to remove once applied, and easily can become identities for children to adopt.

Functional Duplication

The number of labels is large but the number of therapies or interventions is unfortunately small. Since each agency will assist only children with specific labels, duplication of services is widespread. Public Welfare arranges day care for welfare children, Public Health for handicapped children, Mental Health for retarded children, and Youth Services for delinquent children. For day care, the words counseling, residential treatment, foster care, medicine, or a variety of other therapies could be substituted.

Lack of Accountability

The limited responsibility of each agency makes it almost impossible to know where accountability lies when a child receives no services or inadequate services. The existing agencies can easily say, "he is not in the category we assist," and no one assumes responsibility for finding the correct agency. The layers of bureaucracy in the decentralized departments make it difficult to appeal a decision, while the overload in the centralized ones makes it equally difficult to reach the individuals with power to make changes. Accountability is absent.

Inability to Plan

Because no one agency looks at all the needs of all the children, or determines how many children are not being served by any agency and how many are being served by several, it is impossible to plan services rationally. Each agency may be able to determine what additional resources are needed to serve adequately the children with the problems for which it is responsible, but what about the children who will be counted two or three times in such a computation? And, what about the children with problems for which no department currently is responsible?

Advantages of a Single Agency

To alleviate the problems that arise from the current system of providing services to children, the Task Force recommends that a single state-level agency, with area counterparts, be created to assume responsibility for all the children's services currently scattered through many state departments and agencies. This recommendation arises out of its belief that children, the most vulnerable group in our society, should be treated in an integral fashion rather than be categorized by artificial boundary lines - especially since many children, and even more families, fall into more than one category. It is not unusual for a single family to have a child known to Youth Services because of predelinquent behavior, another known to Public Welfare because he is in day care, and a third to a mental health clinic because of disturbed behavior. Reviewing children's records, one is appalled by the number of agencies which have tried to assist a single case. What was the impact on the child and the family of these multiple interventions? Equally puzzling at times is why one agency rather than another becomes involved. Why do some parents go to a family agency, others to a mental health clinic, and others to the local Welfare Service Office for help with a difficult child? Cannot a more rational system be developed so that children can receive better care and agencies need not duplicate records and personnel?

The difficulties that arise as a result of overlapping jurisdictions, however, are less urgent than those caused by the absence of services in many fields of service and in many sections of the Commonwealth. A single non-categorical agency, relieved of the problem of meeting the demands of adults, would be in a better position to determine the gaps in services to children and to reallocate scarce resources. Such planning is almost impossible at the present when each state agency is interested only in a few kinds of problems and when most state agencies must serve adults as well as children.

An agency is needed that can look at children as whole human beings and at the wide range of their needs. This agency should not be added to the existing ones in order to serve a coordinating function only, but should actually assume responsibility for integrating existing services and developing new ones. The executive reorganization process presents Massachusetts with an opportunity to make a clean break with outmoded concepts and to develop a new approach to the delivery of services to children.

The state need not continue to structure its services in the traditional ways: welfare, corrections, public health, mental health, etc. The proposals of the Executive Office of Human Services are a first step in the direction of breaking down historical separations, but they do not go far enough. The Task Force agrees that the various fiscal transfer programs should be separated from the Department of Welfare and placed in a separate and centralized Financial Assistance Administration. It sees the logic of placing a variety of health-related activities, in a centralized Health Systems Regulation Administration.

But the Task Force is distressed at the hodgepodge of administrations which Human Services has decided to decentralize while keeping them separate from each other: Community and Mental Health, Family Services, and Rehabilitation. These administrations are homogenous neither in the populations they are to serve nor in the functions which they are to perform. All three will provide services to both young and old. All three will administer institutions (Community and Mental Health: hospitals; Family Services: detention centers and residential centers; Rehabilitation: schools for the retarded and the Hospital School). All three will counsel or give individual psychological therapy. All three will be concerned with day care. And the list could be continued.

This regrouping is the first step to a more reasonable system, but for children and youth particularly, it is not a large enough step. The Commonwealth must do more than reduce the number of agencies in Human Services with partial responsibility for children's services from four Departments to three Administrations. It must form a single children's services agency which will integrate the children's services currently provided by the several Departments and the Office for Children within Human Services with the Special Education Division of the Executive Office of Educational Affairs and the services for children and youth of the Executive Offices of Communities and Development and of Manpower Affairs.

A state agency responsible for all state services to children, other than education, would be in a position to:

1. ensure that the needs of children are recognized and given higher priority;

2. emphasize the preventive and early intervention approach;

3. provide greater accountability;

4. utilize more efficiently the funds currently available by looking at the needs of children generally rather than dividing them into categories;

5. document the unmet needs of children in such a forceful fashion as to justify the demand for additional state and federal funds; and

6. develop a strong liaison with the Executive Office of Educational Affairs, with the potential for strengthening the services of both agencies.

An Overview of State Government Categorical Programs

This review of the many state agencies offering services to children and their families will not mention every program; little attention, for example, will be paid to the important consultation and education functions. A total accounting of all programs might be the first task of a state children's services agency, but it is not the assignment this Task Force undertook. Rather the objective of this summary is to acquaint decision makers with the wide array of programs whose objectives, so far as children are concerned, would be better served if they were integrated within one agency.

Executive Office of Human Services

This Secretariat which in fiscal 1972 managed 55.5% of the entire state budget[8] includes four Departments which have a major impact on children, plus the Office for Children.

Mental Health:[9] The Department of Mental Health (DMH) operates mental health and retardation facilities for both children and adults, including state mental hospitals and community mental health centers, mental health clinics, court clinics, drug treatment units, schools and other services for the retarded, and community residences. But, as two community study groups[10] recently discovered, it is extremely difficult to obtain data which separate services to children from those to adults.

The Department has released figures on 41 of the 55 Community Child Psychiatry Clinics developed in partnership with local associations for mental health. During 1971, 34,415 children and adult patients were seen in these clinics. In-patient facilities specifically developed for mentally ill children, however, are almost non-existent, as documented in the previous chapter.

Services for mentally retarded children as of February 1973 included community clinical nursery schools serving 1,161 pre-school children, day care services assisting 71, and the five state schools and one regional center housing 2,223.

DMH also assisted 1,811 drug abusers and drug addicts aged 18 and under in the first six months of 1972 through its support of hospital, clinic, and community self-help drug treatment facilities. These services, however, were insufficient to meet the needs of the many adolescents who have become involved with alcohol and drugs, ranging from glue sniffing

to pill popping to mainlining heroin. Experience has demonstrated that the early adolescent user should not be placed in programs with older users and addicts, as is now often the case; but rather should receive services geared to his special needs and problems. Adolescent mothers who are also addicts present special problems. Both the mothers and their infants are at high risk for poor outcomes and in need of special care.

Although DMH operates a wide variety of services, they are neither evenly distributed across the Commonwealth nor adequate to meet the needs. The presence of an in-patient unit in Waltham is of little help to the parent of a disturbed child in Springfield. The day care units for autistic children at the Eric Lindemann Mental Health Center, the Worcester Youth Guidance Center, and several other centers, are insufficient to meet the demand for such services.

(The role of DMH in the 750 Program is reviewed later under the Department of Education.)

Public Health:[11] Currently, the handicapped are the main focus of children's programs in the Department of Public Health (DPH). A wide assortment of services to this group is administered by the Division of Family Health Services.

These include:

Intake, Information and Referral Center;

Handicapped Children's Clinics which meet periodically throughout the state. In 1972, 31 clinics served over 7,000 children;

Pre-school nursery and day-care programs for approximately 150 children;

Programs for deaf and hard-of-hearing children, providing approximately 500 new hearing aids every year;

Children's Developmental Clinic in Cambridge, which offers diagnostic and referral services to children with developmental delays. In fiscal year 1972, approximately 150 new patients were evaluated and 325 old patients received continued care from the clinic; and

Epilepsy Control Program, which provides clinical services and financial assistance for drug expenses to an estimated 350 children.

In addition, the Massachusetts Hospital School in Canton, under the Division of Patient Care Operations, provides approximately 150 children with in-patient medical and surgical care along with educational, vocational and rehabilitation services for preschool through grade 12. Four of the six public health hospitals for adults also offer limited services to children.

Various consultation services were offered by DPH's maternal and child health staff to family planning programs, day care groups, programs for pregnant women, and vision and hearing screening programs, during fiscal 1972. Immune serum to prevent rh incompatability

BEST COPY AVAILABLE

was made available in cooperation with the State Laboratory Institute. Three day-care centers were operated under DPH supervision with the children's costs paid by Public Welfare.

During 1972, over 40 neighborhood health centers, 35 in Greater Boston and 14 in other areas of the state,[12] provided care to pregnant women and young children, but these programs were not operated by DPH. Start-up funds, and in many cases, funds for continuing support came from a variety of federal, state, and local sources including the federal departments of Health, Education, and Welfare (Maternal and Child Health Services), Housing and Urban Development (Model Cities), and the Office of Economic Opportunity (Office of Health Affairs). Massachusetts' federally funded Maternity and Infant Care and Children and Youth Projects originally were administered by the Division of Family Health Services through arrangements with six Boston hospitals and nine neighborhood health centers. In June 1972, because of administrative difficulties, the federal government removed the responsibility for this program from the DPH and started funding directly. The proposed 1973 federal budget incorporates these project funds into the federal formula grants for maternal and child health given to state health departments under Title V of the Social Security Act, so the funding of these programs probably will be returned to DPH.

Significantly, DPH was characterized in the Human Services reorganization proposals[13] as "an agency whose major concern has been the licensing and regulation of health facilities, the operation of state hospitals, and the prevention and treatment of communicable diseases." Evidently the Human Services staff did not realize DPH's potential for influencing many areas of maternal and child health.

Public Welfare:[14] The Department of Public Welfare (DPW) is another department offering a wide variety of services, but never enough to meet the demand. The largest group of children affected by this Department are those in families receiving financial support under the Aid to Families with Dependent Children program, 210,992 children as of November, 1972. Although many of these families should be receiving family-oriented casework services according to 1962 amendments to the Social Security Act, few are receiving anything other than general supervision by workers responsible for financial eligibility. Medical care for a large number of pregnant women and children also is paid by DPW through Medicaid.

Direct services to children fall largely within the Office of Social Services. The Division of Family and Children's Services (formerly Division of Child Guardianship) is responsible for foster care, group care, adoption, and services to unmarried mothers. In fiscal 1972, the Division had almost four thousand foster homes serving almost six thousand children. In addition almost two thousand children were placed in more than 110 group homes, half-way houses, boarding schools, and residential treatment units. Of 552 children referred for adoption, 450 were placed. The unmarried mothers program purchased counseling services for this group from agencies throughout the Commonwealth.

The Division of Protective and Special Services provides services to children who suffer inflicted injury, abuse, or neglect. The centralized, inflicted injury and abuse unit which serves the City of Boston and the Greater Boston Region registered 156 new cases in fiscal 1972, bringing its caseload up to 320 children. Neglect referrals, from

these two regions, as well as cases of all types in outlying regions were assigned to regional office Child Welfare Specialists. In 1971, about one quarter of the service referrals to the Division of Family and Children's Services were related to child neglect and abuse. Approximately one-sixth of the 300 Child Welfare Workers were involved in protective services.

The Division of Day Care, which contracts for services, was responsible for purchasing services for over 3,000 children in fiscal 1972. Agreements for day care services for these children were made with 74 day care centers, 9 family day care programs, and 3 after-school care programs. Private "babysitting" agreements were made for about 1,000 children, and about 600 children were placed in proprietary day care centers.

Despite these programs, children do not receive the services they need from DPW. The Department's Advisory Board stated in its 1972 report:[15]

> Particularly desperate is the situation involving child welfare services. One-third of the authorized positions are vacant because of lack of funds. Children in a number of foster homes have no on-going supervision from the Department staff. Because of an increase in court referrals since the Youth Services Commission has cut back on its institutional programs, the Department is severely restricted in the number of referrals it can accept from other sources for foster home and institutional placement.

The newspapers viewed the same situation with even more alarm.[16]

> At least 800 children now are drifting unsupervised in Massachusetts foster homes and other institutions, a situation causing alarm to social workers and independent welfare experts.
>
> The problem is the result of the state's new austerity budget and legislative cuts which prevents the hiring of supervising social workers, and which creates a dramatic staff shortage in the state Department of Public Welfare. But problems of finance and organization have contributed to the problem for more than two years.
>
> The case of Al, one foster child abandoned by his parents, illustrates what can happen when foster children go without professional supervision. When a social worker last saw him in 1970 just before quitting her job, he was progressing normally, and she labeled him "quite stable."
>
> Yet two short years later, in the spring of 1972, Al was shot in the back by a man he was robbing for money to keep up his drug habit.
>
> The difference that could make a thief and drug addict out of a "quite stable" teen-age boy is now a common problem in child welfare: the lack of rehabilitation and social services due to staff shortages.

> These shortages -- up to 50 percent in some Welfare Department offices -- have resulted in the stranding of at least 600 children with other estimates claiming 2,500 children. Currently residing in supposedly "temporary" homes, they are receiving no supervision or aid from the agency that is legally responsible for them.
>
> The cutback in staff supervision is partly the result of two recent setbacks--Governor Francis W. Sargent's austerity program and the Legislature's budget cuts--which prevent the department from hiring the 1,300 persons it claims it needs to keep up with its case work, which includes child welfare.

Fortunately, DPW has been allowed to fill some of the positions vacant because of the austerity budget, but the fact that such conditions were allowed to develop confirms the Task Force's observations about the insufficient commitment to children's needs in the Commonwealth.

Youth Services: The Department of Youth Services (DYS) is responsible for the care and supervision of all children seven to seventeen committed or referred to the Department by the courts. Further, DYS has custody of those detained juveniles who are awaiting adjudication. All adjudicated delinquents not placed on probation are in the custody of the Department which determines the program that the youngster will be assigned to, as well as its duration. Further, DYS is empowered to parole a juvenile or to release him at any time after commitment.

Until 1970, the Department operated four training schools. The closing of these and the two county-operated schools substantially increased the problems of DYS. In order to provide for the youngsters who were released from these institutions and maintain them in community-based settings, DYS developed a broad array of new programs. Concurrently the Department channeled a substantial portion of its fiscal resources into the purchase of services on a contractual basis. These include group care in residential centers, group homes, regular and specialized boarding schools, and residential camps; foster care; and non-residential programs offering individual and family counselling, tutoring, alternative and supplementary educational programs, vocationsl training, employment counselling, and leisure time activities. Currently, more DYS youth are in small, community-based programs than were previously in the large custodial institutions.

The Department operates four secure detention care facilities and seven shelter care facilities for lower risk youth. All provide placement counselling, crisis intervention, job guidance, family counselling, educational services, and court liaison. The Department also uses detention foster homes as an alternative type of emergency shelter care. DYS's Homeward Bound Program encompasses forestry, camping, and outdoor experience. Its objective is to encourage and prepare youth to successfully confront and solve daily life problems.

As of May 1973, DYS was responsible for approximately 2,700 children including 942 in residential care, 764 in non-residential care, 707 under parole supervision and 302 in detention.

Office for Children: This Office was established in the Spring of 1972. Its functions include advocacy, planning, evaluation, and the licensing of day care centers, homes, and systems, foster care, placement agencies,and group facilities. It does not have responsibility for any personal services to children or their families, but does plan to review and coordinate children's services provided by other state agencies and institutions and to study state budgets involving children's services.

Early in 1973, as part of its concern with community alternatives to institutionalization, the Office for Children instituted the Project for Children. Under the Project, private groups which develop programs that can eliminate the need for institutionalization can apply for a year's funding. Only present or potential recipients of public assistance are eligible for services. The Project has available two and a half million dollars which is reimburseable by the federal government under the provisions of Title IV A of the Social Security Act.

Most of the functions of the Coordinated Child Care Committee, (4-C) formerly operated within the State Management and Planning Office of the Department of Administration and Finance, have been absorbed by the Office for Children. The original purpose of 4-C was to coordinate the efforts of all state departments with respect to children's services. The Office for Children currently is developing local Councils for Children, using existing 4-C Committees as a base.

Executive Office of Educational Affairs

Traditionally the Division of Special Education within the Educational Affairs Office has had responsibility for the education of the handicapped child, originally the blind, deaf, and physically handicapped; now aphasic children and those with speech, vision, hearing, or perceptual handicaps are included. The law (Chapter 69) requires that the school committee of each locality establish special classes or develop cooperative agreements with adjacent communities to operate special classes for these children, but the Commonwealth pays the total cost of instruction and transportation. Similar provisions for special classes for the mentally retarded were mandated by Chapter 71. The responsibility of the Division was greatly expanded again when legislation, (Chapter 71, Section 46H) passed in 1960 and amended in 1967, mandated that local and regional school districts "shall" provide for the education of emotionally disturbed children either in regular public school classes or through use of home tutors, depending on the child's needs. This new initiative, called the "750 Program" had two goals: first, to offer educational and mental health services simultaneously and in a coordinated manner to children in need, and second, to offer such services in the local community. Responsibility for the "750 Program" was to be shared by the Department of Education, which was to channel funds and monitor the educational component, and the Department of Mental Health, which was to insure the evaluation of children by qualified psychiatrists and make avaialble mental health services. Local communities were given three years, or until September 1970 to comply with the new regulations. Section 46 I, however, added that the school committee "may" send emotionally disturbed children to private residential and day schools and treatment facilities anywhere in the country, entirely at state expense. This permissive regulation gave communities a loophole which has been exploited to avoid local responsibility and increased the state's cost of providing educational services to the emotionally disturbed. The waiting list for the program is now over 900 children.

To remedy past inadequacies and inequities in educational programs for handicapped children, a new law, Chapter 766 was passed in 1972 to be implemented by September 1974. The program is designed to provide a flexible and uniform system of special education, to strengthen and regionalize the Division of Special Education, to increase parent and community involvement in the planning and operation of programs for handicapped children, and to specify an accountability procedure for evaluating each child's special needs, for placing him in the most appropriate setting, and for re-evaluating his progress periodically. This new law holds significant potential for improving the services available to children and for bringing together both children's services and the educational system in a productive manner.

Executive Office of Communities and Development

The Department of Community Affairs (DCA) within Communities and Development, supervises all services provided to tenants of public housing projects. In the beginning of 1973 the Department offered to expand existing child care and family planning services in fifteen communities, using $395,000 of special federal funds (Title IV-A) through an inter-agency contract with the Department of Public Welfare. Recipients of the proposed services were to be residents of state or federal public housing projects and former, current, or potential recipients of Aid to Families with Dependent Children. DCA has offered technical assistance in the development of such community proposals which must be submitted by the local housing authority with the approval of both the authority and the Tenant Organization. All funds must be assigned before June 30, 1973, and there is no guarantee of continued funding in fiscal 1974.

The Economic Opportunity Office of DCA is responsible for twenty-four Head Start projects across the state, offering part-time and full-time programs to about 5,000 children ages 3-5. All programs require a medical and dental examination of children upon entrance.

The Model Cities Program administered by Communities and Development has projects in Boston, Cambridge, Fall River, Holyoke, Lowell, Lynn, New Bedford, Springfield and Worcester. Each project is responsible for its own mix of services, but most include services for children such as day care, tutoring, health services, and summer programs. In addition, three neighborhood health centers in Boston and 5 outside of Boston receive Model Cities support - contingent, of course, on the continuation of that program.

Executive Office of Manpower Affairs

Manpower Affairs serves children and youth through the administration of child labor laws, (Department of Labor, Division of Industrial Safety), and in 1972 operated three employment programs for young people - Neighborhood Youth Corps, Job Corps, and Youth Conservation Corps-plus the Summer Youth Public Employment Program, initiated under the federal Emergency Employment Act of 1971.

The largest program, the Neighborhood Youth Corps was designed for youngsters in high school (ages 14-22) and is comprised of:

1. an in-school program - which entails 15 hours of work per week, in a non-profit or public agency, with an orientation towards staying in school while

gaining valuable work experience. As of January 1973, about 1,400 children were enrolled in this program.

2. an out-of-school program - which offers a job plus training in a full work week program, including an education component to encourage youngster to return to school, involving approximately 400 youth.

3. a summer program - which includes a 26 hour work week, for 7 weeks during the summer months, in a non-profit or public agency, for youngsters still in school the rest of the year. There were about 18,000 young people in this program in the Summer of 1972. It will not operate in Summer 1973; however, the Summer Youth Employment Program, which last year served 1,357 disadvantaged youth, aged 16-22, will continue.

Federal money supports the Corps' programs on a 90-10 matching basis with the local community.. Again the prospects for continuing support are questionable. The State Manpower Planning Council acts as financial intermediary, evaluating programs, setting standards, and offering assistance.

The intent of Job Corps, funded by the Office of Economic Opportunity, was different from that of the Neighborhood Youth Corps: it attempted to take the youngster out of his environment completely, offering him a new start. Basic needs, such as health and mental health services, clothes, food, housing, job training, and job employment, were provided, and an effort was made to help him develop educational and vocational skills. Although the five centers originally created in New England closed in 1968, recruitment continues but enrollment in Massachusetts is low, between two and three hundred.

Unlike the other two programs, the Youth Conservation Corps is opened to all youth ages 15-18, not only the disadvantaged. The program, established in 1970, is supported fully by federal funds and operated on federal land reserves. Proposals are currently under consideration to develop a similar program with federal support but using state rather than federal lands. Only about 35 are enrolled.

Governor's Committee on Law Enforcement and the Administration of Criminal Justice

Delinquency prevention is the main aim of the children's services provided by this committee which funds programs using federal Law Enforcement Administration Agency (LEAA) money. These programs include Youth Resource Bureaus in five cities which provide counselling and help in finding placements as alternatives to the adjudication of delinquents. LEAA funds also support two court intake programs.

Other Programs

The Task Force is aware that a large proportion of the services received by children are supported by the judicial system (probation), the governments of the 351 cities and towns in the Commonwealth, or by private agencies. A state children's services agency would not supplant these services. Instead, it would seek their assistance in planning a wide range of programs. The state agency might decide to purchase some specialized services from the private agencies, such as adoption services. Local communities might decide to delegate some services to the area children's services agency, for example school nursing. The availability of a state agency responsible for all state-supported children's services and of area offices of that agency would make it easier to develop such collaborative arrangements.

REFERENCES

1 - White House Conference on Children 1970, "Children and Parents: Together in the World," Report of Forum in Report to the President, U.S. Government Printing Office, 1971.

2 - Position Paper on Child Health and Public Policy adopted by the Governing Council of the American Public Health Association, November 15, 1972.

3 - Richard Rowe, Child Care in Massachusetts: The Public Responsibility, Massachusetts Advisory Council on Education, February 1972.

4 - Figures derived from Massachusetts Mental Hospital Planning Project, "Selected Statistics on Patient Movement and Fiscal Expenditures," April 1972. These include the total institutional budgets of 11 state hospitals, 6 state schools, and Cushing Hospital.

5 - Figures based on financial statement in Into the Second Century, a report prepared by the Massachusetts Department of Public Health. The Massachusetts Hospital School which serves children primarily was not included in the numerator. Institutions other than the Hospital School operated by the Department are Lakeville, Lemuel Shattuck, Pondville, Rutland Heights, Tewksbury, and Western Massachusetts Hospitals.

6 - Office for Children, "General Project Description" Project for Children, Commonwealth of Massachusetts, undated.

7 - A similar recommendation has been made by the Task Force on Children and Youth of the Massachusetts Mental Hospital Planning Project.

8 - In fiscal 1972, the state budget was $1,977,044,096 and $1,097,369,496 was appropriated for EOHS. Personal communication from Financial Office, EOHS.

9 - All DMH data are from Department reports or from communications with Department personnel.

10 - The Task Force on Children and Youth of the Massachusetts Mental Hospital Planning Project and the Task Force on Children Out of School.

11 - All DPH data are from Department reports or from communications with Department personnel, unless otherwise specified.

12 - Health Planning Council for Greater Boston, Inc., A Directory of Greater Boston Neighborhood Health Centers, 1972; and Massachusetts Blue Cross, Inc., Directory of Neighborhood Health Centers Outside of Boston, May 1972.

13 - Executive Office of Human Services, Reorganization of Human Services, Commonwealth of Massachusetts, January 8, 1973.

14 - All DPW data are from Department reports or from communications with Department personnel, unless otherwise specified.

15 - State Advisory Board, Annual Report Fiscal 1972, Department of Public Welfare, Commonwealth of Massachusetts.

16 - Article by Robin Wright in The Christian Science Monitor, August 10, 1972.

CHAPTER V

A PREVENTIVE APPROACH TO THE PROBLEMS OF CHILDREN

The Task Force believes that its single most important recommendation is that the Commonwealth, in cooperation with all child-serving agencies, public and private, develop and implement an approach to the problems of children and youth which gives primary emphasis to prevention, early detection, and prompt treatment. Such an approach simply does not exist today when time, effort, and funds are directed almost exclusively at attempts to remedy physical and emotional problems of children after irreversible damage has been done. The problems of battered and abused children, of aggressive and delinquent youth, of neglected children, and of multiple handicapped children, to mention only a few examples, only can be ameliorated by present intervention methods. Certainly these children and their families should be assisted toward more fulfilling lives. They should not be subjected to further injury through avoidance and neglect. But the more reasonable approach would be to try to prevent the occurrence of such problems; or, if prevention is impossible, at least to recognize the problems early so that adequate intervention will arrest the growth of the problem and enhance healthier development. Prevention and early intervention make sense not only for the individual child and his family, but also for the taxpayer. Rehabilitation is a great deal more expensive than prevention.

A service delivery system stressing prevention, early detection, and intervention may mean a reorientation of traditional ways of thinking in Massachusetts and in America generally. The pioneer heritage of independence has made this society reluctant to provide assistance unless it is requested. Over the years, this stance has been modified, particularly in regard to neglected or abused children; but the basic concept of non-interference has remained. This philosophy combined with heavy case loads, small budgets, and a "don't look for trouble" attitude, has resulted in agencies concentrating primarily on cases of relatively serious pathology with minor attention to prevention and early detection.

In this chapter, actions which would promote a preventive approach to the problems of children will be recommended. These include developing an environment that enables children to develop their fullest potential, and requiring that services be available to children throughout the Commonwealth which will prevent problems from arising, detect problems early, and treat problems promptly in order to limit their consequences.

Later chapters will recommend changes in the structure of government at the area and state levels which would make possible the implementation of such an approach.

Developing a Healthy Environment

The most significant measures which can be taken in the area of prevention are not addressed to the individual child, but to the environment into which he is born and in which he develops. A child born in perfect health may rapidly acquire physical and emotional handicaps if the situation in which he grows up not only fails to promote his

well-being, but actively detracts from it. Among the aids to normal development are:

1. adequate family income,
2. equal opportunity regardless of race or other minority group status,
3. access to adequate health care,
4. responsive education system,
5. adequate housing, and
6. sufficient recreational facilities.

Poverty

Children have difficulty developing in a positive fashion if their day-to-day existence is blighted by poverty. The damages due to deprivation are physical, cognitive, and emotional. The child whose family has inadequate income eats less nutritious food and has less protective clothing and shelter. He is exposed to fewer activities and materials which can stimulate his intellectual development. He observes the differences between his style of life and those of the more affluent, and wonders about his own worth.

Society looks down on individuals who cannot support themselves and their children. This attitude punishes the children who are innocent. Society's anger at the parents strikes hardest at the defenseless children.

A recent report[3] on the role of state government in fighting poverty stated:

> To create a foundation from which the poor can operate as effective individuals means to assure them a minimum adequate income. In practice, this means more and better jobs for the poor, and a federally supported program of family income maintenance.

The Task Force agrees with this prescription and urges the Commonwealth to take immediate action to increase jobs and, while awaiting an adequate federal family income maintenance program, to increase welfare payments to families with children.

Racism

The prejudicial attitudes of employers, teachers, welfare and medical personnel, and many other individuals toward the non-white and non-English speaking segments of the population are a powerful barrier to the healthy development of minority children. They block the child's access to goods and services, and, more important, warp his self-image and thus hamper his performance of the activities necessary to secure his portion of society's resources. State and local governments should take deliberate action to eliminate from the ranks of their employees all those who show racist attitudes, and do all in their power to ensure that all who serve children and their families do so without prejudice. The public schools have the potential for promoting positive attitudes and they should be encouraged to develop curricula in this area. Schools of education also should take an active role in alerting potential teachers and administrators to the dangers of racism. State and local children's services agencies should assume leadership roles in assuring all children equal access to services regardless of race, economic status,

or ethnic background.

Services and Facilities

The Task Force agrees with some additional statements from the previously cited report on state government:[2]

> But income is not enough. Services are required. In the case of the many poor, who, for good reasons, cannot hold jobs and make do on their own resources, various programs of intensive services must be provided by a welfare establishment freed of its enormous case load by the guaranteed-income program. And beyond this lies the whole question of services to which the private market is not presently responsive: day-care centers, family-planning programs, housing, education, health care, police protection, consumer protection, and many others. All these services are needed by the entire population, and by the poor especially. To deliver them to the poor is to deliver them to everyone, and to assure the poor access to them. To deliver them to all is, moreover, to remove the stigma attaching to services delivered exclusively to the poor and so to make such services more accessible to all the poor.

The services which particularly demand state attention at this time are education, medical care, housing, and recreation.

If schools could develop curriculum and recruit additional teachers who are responsive to the current needs of students, they might be able to prevent the many problems which arise when children leave school early, or graduate without an adequate education. Schools should reach out to families and involve them in the educational process. Such activities have the potential for encouraging a home climate conducive to the learning process and preventing the development of children who have "dropped out" psychologically by the third grade.

Better distribution of high quality health care and its provision, without financial barriers, in settings which are both accessible and acceptable would play an obvious role in the prevention of a variety of adverse conditions.

Housing should be generally available which not only avoids the hazards of lead-based paint, rats, and other unsanitary conditions, but which provides a protecting and stimulating environment. For the child, a home is not merely floors, walls, and ceilings, but a place to play and to learn. Housing should be designed to maximize the possibility of favorably affecting children.

Finally, opportunities for healthy recreation and social activity, both indoors and out, should be provided for children in all communities. Their absence frequently contributes to the opportunities for anti-social behavior; their presence to normal development. These services and facilities are vital to the preventive approach.

The American Academy of Pediatrics' 1971 report[3] summarized the importance of environmental factors and the need for action as follows:

> There are several major factors which prevent achievement of optimal health care of children. First among these is

a group of environmental, social, and cultural factors including poverty, pollution, inadequate housing, malnutrition, ignorance, and prejudice. Poverty is the greatest of these. We have also become increasingly aware of the vast problems resulting from environmental pollution, be it from the air, the water, or from radiation or dangerous drugs. The recognition of the influence of these factors on health may come largely from medicine and related sciences, but their elimination requires that the sociopolitical structure of American society determines that they are evil and that they must be eliminated, despite the monetary cost. Inasmuch as the essential strengthening of health services will not, in itself, ensure the attainment of the goals set forth in this Report, we recommend that:

All levels and facets of government join with the public and the health professions to identify, attack, reduce, and eliminate the many environmental factors which are a deterrent to optimal health. Legislation, education of the public, and a massive financial investment are needed.

Essential Programs

Children throughout the Commonwealth should have available a wide range of services to prevent problems when possible, to detect problems early, to treat problems vigorously and promptly so as to limit their consequences, and to enable those with problems to live as normal a life as possible. The Task Force believes it is the responsibility of the Commonwealth to see that such services are available. This does not mean that the Commonwealth must deliver all these services. Many of them currently are, and should continue to be provided by local governments and by agencies and individuals in the private sector.

Nor does it mean that every service must be available in each locality. Many services, such as cardiac surgery, are required by only a small proportion of the child population. These services should be available only in specialized centers, but the Commonwealth should take the initiative in determining that the services are available, in ensuring that there is access to the more specialized and centralized services, and in providing directly or through contracts those services which are not being provided by others.

Children's services are not services exclusively for children, but services to the family unit with emphasis on the child. While experienced workers in the children's field always include the family in their treatment of the child - and this is true of social workers, psychiatrists, probation officers, guidance counselors, and others, - the same, unfortunately, cannot be said of actions taken on behalf of the adult members of a family. Often little or no attention is paid to the consequences of a parent's treatment for the children, as when a mother is placed in a state hospital without checking that provisions have been made for their care. Experience suggests that it is easier for a children's agency to consider the needs of all the family, than for an agency focused on adult problems to think about the needs of the children of those adults.

Finally, although the Task Force believes that the Commonwealth should ensure that services are available, it is reluctant to recommend that specific individual services be mandated by state legislation. Such legislation is an invitation to cynicism. While it is relatively easy to pass legislation requiring that services be given, thereby raising parents' hopes, all too often insufficient funds are authorized to implement the legislative mandate. The 750 Program provides an unhappy example. There is no need for citizen distrust of state government to be increased through the process of mandating services which then are not provided. The failure to provide mandated services was frequently raised as an issue by individuals responding to the Task Force's request for comments on children's services. In addition, as needs change and new patterns of service evolve, mandated services soon become outdated and change is required through the cumbersome legislative process. A more satisfactory alternative would be to mandate the types of programs which should be available, such as special education or protective services, and to give to a state children's services agency responsibility for prodding the legislature to provide the funds for such programs and for promulgating, keeping current, and enforcing policies about the specific services which should be available at the local and state level.

Prevention of Problems

A first step in the prevention of physical and emotional pathology in children is the promotion of the health of pregnant women. Not only should prenatal services be available in all areas of the Commonwealth to women who seek them, but outreach services should encourage those pregnant women who are reluctant or uninformed to obtain prenatal care. Special attention should be directed to the pregnant addict.

Society is becoming increasingly aware that unwanted children are at high risk for a variety of problems. The home, religious organizations, and the school can help prevent these problems by assisting children and youth to understand the responsibilities of family life. While family life educational programs have the broader objective of preparing youth for parenthood, sex education is an important component which should not be omitted. Programs should begin at an early age and continue through high school and college, with curriculum geared to each age group. At the appropriate age, subjects such as anatomy and physiology, venereal disease, prevention of pregnancy, and personal hygiene should be discussed.

Each area should have clinics and other facilities at which advice about family planning and contraceptive devices would be available not only to married women, but to teenagers and unmarried individuals of both sexes. And since unwanted pregnancies cannot always be prevented, many services are necessary to assist those facing this problem, including counseling about the possible alternatives. For those who wish to carry the pregnancy to term, adoption, casework, and special programs for teenage parents are required. For women who wish to terminate their pregnancy, facilities should be developed at which abortions can be obtained, in line with good medical practice and state law. (For separate statement of Dr. Guthrie, Mr. Shea and Ms. Sullivan see page 75.)

Programs of immunization must be continued and stepped up to ensure that no child contracts, and no unborn infant is affected by, a disease which society now has the power to prevent.

Ample evidence indicates that for a large number of families, the naive assumption that biological mothers and fathers instinctively know how to be good parents is untrue. Much can and should be done to educate parents to the physical and emotional needs of children. They should be helped to understand normal child development and the factors which help children grow in a healthy way. Such programs should start before individuals become parents - they should be a large component of the family life education program of schools, religious organizations, and other agencies. In addition, special efforts should be made to educate new parents in their homes by using various types of outreach workers selected for their ability to communicate with people within their geographical area and then given special training in specialized fields. Parents also should be urged to participate in informal classes and group discussions held in neighborhood centers on subjects such as child-bearing, consumer protection, and home management.

Adoption services should be readily available so that children whose parents are unwilling or unable to care for them are placed expeditiously into suitable adoptive homes in order to prevent psychological or emotional trauma.

Day care programs with staff and facilities which optimize a child's physical, emotional, and mental development also can serve a preventive function. Each area children's services agency should promote such programs and study their adequacy.

Finally, greater efforts should be made to educate those who come in contact with children in the course of their work. This education would include not only teachers and social workers, but also police, lawyers, clergy, and many others. Their education in child development and child-rearing should begin in college and professional schools. Area agencies should make sure that they keep abreast of current developments by providing consultative services to various child-serving agencies, including schools, courts, and law enforcement agencies, and by continuing programs of in-service education. State government could take the lead in encouraging such education by insisting that children's agencies under its control employ only those specially qualified in child development, either through experience or training. Experience working with adults should not qualify individuals to work with children, whose needs and problems are so different.

Early Detection

Early detection of problems can be achieved by two mechanisms: periodic assessment of all children, and maintaining active communication with those agencies or individuals who might detect early trouble signs.

The physical and emotional health of children should be determined through examinations by physicians and allied health personnel on a regular basis. Such examinations should include developmental tests to check progress in this area as well.

Moreover, in situations involving a high risk of a poor emotional or physical climate for a young child, periodic home visits should be made by outreach workers. These visits would serve not only to evaluate the child's home condition, but also to provide supportive services to the parents. Examples of such high risk households would include those with school-age mothers or with parents who have a history of mental illness, major emotional problems, anti-social behavior, alcohol or drug abuse, or child neglect.

Area children's agencies should develop relationships with schools, clinics, police, and other agencies and individuals serving children so that they are contacted automatically when anyone has a suspicion that a child may be experiencing difficulty. For example, a juvenile police officer might inform an area agency about an aggressive acting-out child before he developed a police or court record, or a school might wish to discuss a child having learning problems. Concerned individuals also should be encouraged to contact an agency when they suspect a child needs help. Neither the periodic assessment nor the reporting will be of significant value, however, unless the agency responsible for these functions checks that all detected or suspected problems receive prompt evaluation and effective treatment. A computerized service registry would increase the efficiency of such follow-up. (See section on service registry in Chapter VI).

Prompt Treatment

Once problems are confirmed, personnel and facilities must be available for prompt and vigorous treatment to reduce the severity of their consequences. Mechanisms for achieving such treatment are described in the next chapter on the organization of children's services at the area level. They include an information and referral service to which all children and their parents could turn for assistance in locating the service they need, a multiservice children's center, and a children's services worker.

Medical care should be available in all areas to the acutely ill and injured on both out-patient and in-patient bases. Emergency medical and psychiatric services should be maintained around the clock. Health care for the chronically ill and handicapped should be provided for both in- and out-patients within each area when feasible, and at the regional or state level when specialized types of therapy were needed. Services should include periodic re-evaluation of the status of the illness or the handicap.

Psychiatric and psychological care, casework and counseling, and legal services should be maintained for children and youth with a wide variety of problems including those who are mentally or emotionally ill, drug dependent or addicted, pre-delinquent or delinquent, teenage parents, and those with perceptual handicaps, learning disabilities, and developmental deviations. Such services need not be provided only in clinic or agency settings, but might be more accessible and acceptable within a child's neighborhood, at a settlement house, boys' club, or school.

Various kinds of supplemental or supporting services should be offered to parents to assist them in keeping children in their own homes, when this seems the best place for the child. Such services would include psychiatric care, casework and counseling, and legal services to the parents of children with special needs, i.e. the physically, mentally, or emotionally ill, mentally retarded, addicted, pre-delinquent or delinquent, and neglected or abused children. Other necessary services include therapeutic day care for those with special needs; visits to the home by nurses and other outreach workers to provide direct care, to supervise, and to support; and homemaker services to help keep families together during times of stress.

When it is not in the child's best interests for him to stay in his natural home, either because of his need for special services or because of a destructive home environment, alternative living arrangements

should be available, both temporary and permanent. These should include foster, group, and adoptive homes both for relatively healthy children and for those with special needs, and should serve children from infancy on. Small residential units, halfway houses, partial hospitalization, and other settings should be available for those children and youth who do better outside of a home environment. The child should be carefully matched to the placement to make sure it meets his needs and to avoid the shifting from placement to placement which has been the pattern.

The responsible agencies should be required, however, to continue their efforts in behalf of children even after they are removed from their natural homes. Placement should not be an end in itself, as it unfortunately has been. The need for nurturing continues into alternative living arrangements. Placements should be periodically checked to ensure that the personnel and the physical facilities provide a healthy and stimulating environment and that necessary remedial services are received. Pre- and in-service training should be available for foster parents and those who operate group settings.

Various types of short-stay centers also are needed to meet special situations. These include secure arrangements for children awaiting court appearance or placement, and emergency shelters for children whose homes have dissolved or who have run away from home.

Special schools, educational programs, and sheltered work experiences should be maintained to educate and rehabilitate children with a wide variety of problems which might preclude their attendance at regular schools. These would include the mentally ill, retarded, handicapped, disturbed, aggressive, pre-delinquent, delinquent, drug dependent and addicted, and pregnant.

The placement of children in large custodial institutions should be discontinued and the institutions phased out. While specialized acute care hospitals and schools still will be needed to treat acute conditions until they are stabilized; smaller, family-type programs on a residential or day basis should be developed within the areas for those with long-term problems.

A Non-Categorical Approach

The Task Force has chosen deliberately not to list these services by the type of problem, but rather to stress the methods of preventing, detecting and treating these problems. A new, and hopefully more effective approach to children's services should include breaking down barriers which, for example, have separated services to abused and neglected children from services to handicapped children, or services to mentally ill children from services to pre-delinquent children. The next chapter will suggest how this approach would be implemented at the area level through Children's Councils, Children's Services Workers, and Children's Service Centers; and the following chapter will outline the responsibility of a state agency in supporting the area councils and setting state-wide policies.

REFERENCES

1 - Richard E. Barringer, "Epilogue: Poverty and Priorities" in The State and the Poor, edited by Samuel H. Beer and Richard E. Barringer, Winthrop Publishers, Inc., Cambridge, Mass., 1970.

2 - The State and the Poor, previously cited.

3 - Council on Pediatric Practice, Lengthening Shadows, American Academy of Pediatrics, 1971.

CHAPTER VI

CHILDREN'S SERVICES AGENCIES AT THE AREA LEVEL

The preventive approach to the needs of children, described in the previous chapter, needs to be implemented at several levels. Changing public priorities and measures to develop a healthy environment call for social action focused on state and federal governments. In fact, improvement of the total environment within which the child develops, an environment which is clearly harmful to many children, requires a social movement addressed to changing some of the basic principles of American society.

The present situation in regard to income distribution and resource allocation is not a result of deliberate decisions by individuals who want to neglect the welfare of children, but rather the result of misapplication of concepts deeply imbedded in the American culture: that the family has the primary responsibility for the upbringing of children, that the initial social and economic status of the child is identified with the status of the parent, and that inequality in the distribution of incomes reflects differences in the contributions of particular persons to the total economy. Although individual members might support the social movement necessary to change the application of some of these principles, the Task Force as a whole has chosen to restrict its recommendations to those which can be implemented within a narrower compass.

Within the Commonwealth there is an urgent need to reorganize and consolidate services at the area level in such a way that the responsibility for the delivery of services is close to the children in need. The structure the Task Force recommends is based on a strong belief in community participation in the planning, execution, and evaluation of services. The system would be developed, therefore, by Children's Councils, composed of individuals who live or work in the area to be served, under the guidance of a state agency. The cornerstone of the area delivery system would be Children's Service Centers.

Areas should serve a population of between seventy-five and two hundred thousand people. In delineating such areas, attention should be paid to problems of access and transportation, as well as to existing school districts, mental health areas, and other jurisdictional lines.

Functions

Each Children's Council would be responsible for assessing the needs of children within its area, for developing programs to meet those needs, and for evaluating the effectiveness of those programs within guidelines established by the state children's services agency. In order to perform these tasks, each Council would need legal authority to receive and disburse funds, and a director supported by competent staff. Policy-making would be a Council function, while operational responsibility would be lodged with the area director.

The funds under the control of the Councils would be used not only for Council functions; but also to pay area-level state employees for direct services to children and to purchase services from state or regional level public institutions and from private agencies and organizations. (In situations where a public or private agency served both children and adults, the Council would purchase the children's services.) Thus the Councils would be both the employer of service personnel and the contracting agent for purchased services.

Planning

Each area Council would be responsible for planning children's services within its area in cooperation with other public and private agencies. The range of services needed in each area has been discussed in the previous chapter and would be incorporated into guidelines established by the state children's services agency. The area Councils first would have to determine whether the services were being provided adequately or at all, and then proceed to develop a plan to overcome deficiencies. Insofar as federal funding regulations would permit, the Councils should be encouraged to move away from the present bureaucratic organizational structure which categorizes children's services as welfare, delinquency, medical, or psychiatric. Such an approach would only perpetuate the present chaotic system. Rather, the Councils should consider how best to develop a complete range of services integrated around need and oriented toward prevention and early intervention and with specific attention to prompt treatment.

Delivery of Services

Each Council would assume responsibility for all programs operated for children in its area under the control of state government, with the exception of general schools. These would include the services and facilities of the following: the Office for Children and the Departments of Mental Health, Public Health, Public Welfare, Youth Services, Special Education, Community Affairs, and others reviewed in Chapter IV.

On the basis of its assessment of the area's resources, the Council would decide under what arrangements to maintain these services and facilities, as well as what new programs to establish. Some of the existing state programs might be retained in basically the same format; others might be delegated to private agencies from whom services would be purchased. Some new facilities might be planned for direct administration such as a Children's Services Center, or private agencies might be urged to undertake new functions.

Each Council also would have responsibility for children from its area residing in facilities operated by the state children's services agency, and for those in facilities outside the Commonwealth. Included in the area budgets would be an item to reimburse the facilities for the cost of caring for these children at rates established by the state agency. If an area believed it could provide better care for its children in a smaller, area-operated program, it would be allowed not only to remove them from the state or out-of-state facility and place them in the area program; but also to shift funds

from the reimbursement line of its budgets into funds available for operating such area programs.

No single model of service delivery would be equally applicable to all areas. The decision about the most appropriate mix of direct service and purchase for any area should be made by its Council. The state agency director would have the responsibility, however, to make sure that area Councils knew the variety of options available.

Since, unfortunately, the range of alternative models of delivery is somewhat narrow in Massachusetts, the state children's services agency should fund several demonstration projects. Communities willing to experiment would be given the funds and technical assistance necessary to try new approaches to delivering services to children. Evaluation of such demonstrations would be mandatory so that other areas could benefit from the experience.

Children's Service Center

The focal point of the delivery system within each area would be a Children's Service Center. Each area Council would be required to operate at least one such multiservice center at which any child or his family could find prompt, efficient, and competent help, even if later they were sent elsewhere for the special services needed to help solve their problem. Areas serving large numbers of children or experiencing many types of problems might need several centers to avoid overloading the facility and the resulting denial of services. The Center would provide an additional method of entry into the system of agencies which provide services to children; it would not replace any of the existing methods. Parents would still be able to take their children to a sectarian or non-sectarian family or children's service association, an out-patient clinic, or a mental health or other facility without first notifying the Center.

Such a Center would satisfy the need expressed by one respondent to the Task Force's inquiry:

> Children and youth services will never be entirely effective until a child or a parent can simply walk into an office specifically for children and youth and ask for help. I mean help of any degree, help of any nature, just plain help! I sincerely believe that until this situation is possible, we will merely continue on as we have been, with a more or less hit or miss, pot luck type of availability of services. What I mean is, if a child or parent seeks assistance and happens to ask for help from an individual who happens to be educated in the specific service required by this parent or child, this person has made a lucky hit. Unfortunately, a very small percentage of the people in need of specific youth services are this lucky. (Thomas S. Bennet, Director, Island Youth Center, Martha's Vineyard)

The direct services provided within a Center would vary from area to area depending on local needs, the services already available in the area, and the decisions of the Councils about which services to provide directly and which to purchase. Such local decision-making would result in several types of Centers varying from those which offered few direct services within their confines to those which housed a wide range of medical, counseling, educational, and recreational facilities.

Conceivably, Centers might be developed which only housed a Director and the staff necessary to maintain minimal supporting functions, such as an information and referral center and a service registry. In such instances, the Council would have decided to purchase all necessary services from private agencies or to disperse its employees through other agencies.

Most Councils, however, would probably decide to continue to support many current state services, and perhaps to develop additional ones, and to have some of these services provided within the Center. The Councils should not feel constrained to continue to deliver services in a categorical manner. Rather, Centers which assume a wide range of direct service functions should consider developing a different approach focused around a new type of generalist, a Children's Service Worker (CSW).

Children's Services Workers: CSWs would be generalists in the field of services to children. Their training would emphasize a thorough knowledge of the child development process and the needs of children at various ages. In addition, they would be familiar with local and state agencies in a wide variety of specialized fields and, of equal importance, thoroughly aware of the characteristics of the area they serve. They should feel equally comfortable working with a judge, a pediatrician, a child protection worker, a psychologist, or a social worker.

CSWs would be recruited from among qualified state personnel and citizens of the area, and trained specifically for the position. Multipurpose centers have experimented successfully with utilizing such individuals to deal with a variety of problems, rather than using a group of highly-skilled social workers and other professionals each of whom was a specialist in his own area. The CSW generalist, if he had a small case load, would be expected to visit homes, to take responsibility for helping children and their families get to the facilities which could assist them - even taking them when necessary - and for continuing to follow the case even if specialty care was required for a brief, or prolonged time. The CSW would become the child's or the family's advocate, doing as much for the family as he could by himself and then working to find sources of additional care as needed - and when the needed services were not available bringing this fact to the attention of the Director for action by the Council. To quote one of the many Task Force respondents who cited the need for a child advocate who would enable young people to derive maximum benefit from the total system of services, schools, jobs, etc: "An adult with a great deal of clout to move the youngster through this labyrinth - someone who does follow through." (Dr. Jerome Miller, former Commissioner, Department of Youth Services). Such a worker

would reverse the trend toward creating a new type of worker for each type of problem and would conserve the small resevoir of professionally trained personnel.

The CSW with a broad range of practical information about child development, agency resources, and his community, would serve as the front line staff person, but would not be expected to take responsibility for independent decision-making in complex or crucial situations. In such situations he would turn to his supervisor. The intent of employing CSWs is not to deny the need for specialists; obviously many problems require an individual with a high level of professional training. It is to reserve specialists for such situations.

In order for the CSW to function effectively, an initial training program and continual education and supervision would be essential. Each Center would need one or more supervisors, depending upon the size of its staff and case load. The pre-employment and on-the-job training would be a joint responsibility of the local and state agencies. In addition to the CSWs, each Center would need to have one or more staff members performing such specialized tasks as finding foster and adoptive homes, unless such services were purchased, and a number of consultants in a variety of areas to assist CSWs and their supervisors in technical fields.

CSWs would be recruited and screened by the area Children's Services Director and his staff, and appointed after review and approval by the Personnel Committee of the Children's Council. The qualifications for the position, in terms of education and/or experience, would be established by the state children's services agency. In order for former state employees to be reassigned as CSWs, they also would have to be approved by the Director and the Personnel Committee and, if approved, participate in the CSW training program.

Operating Procedures: A parent and/or child might come to or call the Center first when a problem arose, or might seek help from the Center because they were dissatisfied with the services they were receiving elsewhere. The family would be assigned immediately to a CSW without a complicated or delaying intake procedure. Unless there was an emergency situation, the CSW, in addition to listening to the immediate presenting problem, would make a comprehensive assessment, reviewing the entire range of problems which the child might have including medical, emotional, behavioral, and educational. On the basis of this review and consultation with his supervisor, the CSW would decide whether he could assume responsibility for the family or whether the case should be assigned to one of the specialists in the Center or to a specialized agency in the area. If the case did not require specialized care, the CSW would be encouraged to handle all the child-centered problems of the family whether they were in child protection, delinquency, mental health, or other areas. CSWs would be expected to visit the homes of the families they were assisting to gain greater insight into their problems. Although specialists would be available, locally and regionally, the aim of the Center would be to try to avoid referral to a specialist unless the CSW felt he could not handle the case under supervision. This system would be easier on the family, who would have to relate to one rather than many helping figures, and prevent the loss of families which often results from referrals without follow-up.

In cases where referral to a specialist or specialized agency was essential, the CSW who did the initial interview would be responsible for checking to determine whether the family had received the necessary services. A case would not be forgotten or closed when a child was referred, because other members of the family might continue to need support and the child and his family might need the help of the CSW after his period of specialty care was completed. The CSW in his advocate role also would check periodically to make sure the family was satisfied with the services it was receiving and that the child was making progress.

Physical Facilities: In some communities the Council might rent space for the Children's Service Center, but in many areas there already might be a structure which was identified as a source of many children's services, and the most expeditious process would be to move into that building and, starting with the existing program, to add the other services necessary for a full range program. Examples of such facilities are community schools, comprehensive service centers, neighborhood health centers, multiservice centers, and community mental health centers.

The area Council also might provide office space within the Center for many or all of the specialized services which it funded in the area, such as special nursery schools or clinics. In addition, it could offer space to agencies and organizations from which it purchased services, such as protective agencies. Finally, to maximize coordination of services directed at children, it could urge individuals from other child-related organizations, such as juvenile police officers, school guidance counselors, or school nurses, to utilize space in the Center.

Information and Referral

Each area agency would maintain up-to-date files on all services to children within the area and the Commonwealth. This information would be available to anyone who came to the Center during its normal hours of operation, and by phone in the evenings and on weekends through the use of an answering service and rotation of staff. Staff would be trained not only to answer the specific question of the parent or child who called or came in, but also to make clear that the Center was available to review the child's overall situation, if such a review was wanted. Families who decided to accept this service would be given an appointment with a CSW.

Service Registry

Each area agency also would maintain a service registry of children to whom it was providing services through CSWs and of certain "high risk" children. Such a registry would provide a way of ensuring that children who needed services did not get lost. To do this, it would be necessary to indicate when the child's case should be reviewed at the time the case was entered into the registry and each time it was up-dated because a service was performed. If the problem was an urgent one, the case might be reviewed in a week or two. If the problem was less pressing, six months or a year might be allowed to elapse before the case was reviewed. Thus the registry would have a monitoring function; ensuring that service goals were checked periodically and that lapses in performance were located early.

The registry also would assist in planning by providing accurate information on which services were being used to a greater or lesser extent and which services were in short supply. It also would help identify agencies or organizations which were not performing in a satisfactory manner.

A registry with such a broad range of functions obviously could not be maintained on a manual basis. Each Center would need to be linked to a computer and have personnel trained in how to enter and retrieve information, as well as how to request and interpret statistical reports.

The material in the case registry would be limited to that essential for providing services and be kept confidential. The reasons for the registry would be explained to parents and their permission obtained for including their child. (The child would receive services even if permission to enter into the registry was not received.) Information from the registry would be available through his supervisor to the CSW handling a case. If other agencies requested information, and the supervisor thought the request was appropriate, the agency would be allowed access only after obtaining parental permission. Additional safeguards to ensure privacy would be developed as needed.

The Governor's Committee on Child Abuse[1] has stated:

> A central registry of all suspected cases of child neglect and abuse is necessary if we are to protect adequately the lives of children, many of whom receive care in one hospital or through one agency and subsequently are referred to another hospital or agency without knowledge of the previous referral.

Although the Committee suggested that such a registry of neglect and abuse serve the entire state, an area service registry would expedite input into the centralized core. The Governor's Commission on Adoption and Foster Care[2] also called for "an effective information and client tracking system . . . to aid social workers and administration in knowing the status of each child under their care and in assuring his well-being." Michigan has instituted a computerized Child Care and Placement Information System which tracks children receiving services related to foster care, adoption, delinquency, protection, youth assistance, and the court, and alerts workers to re-evaluate and follow them up.

Program Monitoring: Each Council would be responsible for monitoring all programs for children in its area, both those which it operated and those operated by others. It would be accountable for both direct and purchased services. Such monitoring would be done by technical specialists either on the area staff or on loan from the state agency. When an employee or an agency was performing below standards, the area director and his staff would suggest ways to improve the calibre of the services. If the situation did not improve within a reasonable time, it would be reviewed with the Council and the appropriate action taken. The Council should be given the power to remove its own employees who were not performing satisfactorily and to withhold funds

from agencies who were not meeting its standards. Employees and agencies should have the right to appeal such decisions to the state Council.

Although the area Councils would not monitor the facilities operated by the state agency, they could effectively indicate disapproval of the services provided children from their area by removing them from such facilities and substituting an area-operated program.

The area monitoring function should not be confused with licensing which would be a state agency function. An area Council could only purchase services from a licensed facility, but it would not need to purchase services from a facility it believed inadequate even if the facility was licensed.

Organization

To enable these functions to be performed effectively would require a strong local governing mechanism with considerable power. The Task Force proposes the area Children's Council as such a force.

Council Selection

Although the Task Force realized that the calibre and commitment of the Council members would be crucial to their effective operation, it did not believe that this report should establish a method of selecting members. The Task Force does recommend, however, that at least half of the members be parents of children under 18; and an equal number of consumers and those with professional expertise about some aspect of children's services be appointed. It also suggests that after the appointments are made the Council members be allowed to vote for additional members, increasing Council size by twenty-five percent, if they believe this will permit more adequate representation of segments of the area's population or important area organizations. The Council, however, would have to retain the 50-50 consumer-provider ratio.

Council membership would be for a three-year term, staggered so that one third of the Council seats would be vacant each year. Council members could not be immediately reappointed or selected but would be eligible for another three-year term after a lapse of one year.

Council members would be reimbursed from Council funds for expenses incurred in attending meetings of the full Council or its subcommittees, or in performing other functions at the Council's specific request, such as visiting local agencies or consulting with state staff. Such expenses might include transportation and babysitting costs, but not loss of pay.

Budgeting

In the fall each Council would prepare a budget of its anticipated expenses for the following fiscal year. It would then conduct an open meeting at which it would review its activities during the past year and its plans for the next one in relation to the proposed budget. The public would be urged to comment on the Council's activities and the budget, but

the Council would make the final decision on the budget to be forwarded to the state children's services agency. The state office would make whatever modifications it felt essential, and then send the budget with the revised area figures back to the areas for their review. If an area believed its needs were not adequately provided for, it could ask for an opportunity to appeal the decision to the state agency. The director of the state agency would have final budgetory authority. The problem of aligning the proposed budgets with categorical federal funds would have to be considered at all levels.

State law should permit area Councils to shift specified portions (perhaps 10%) of their funds from item to item within their budgets. (See Chapter VIII).

Staff Recruitment

Each Council would employ an area Children's Service Director who met the qualifications in terms of experience or education established by the state children's services agency. The area Director, in turn, would select whatever staff was necessary to assist in the functioning of the Council and to perform such direct service functions as the Council decided to support either within the Children's Service Center or elsewhere in the area. The Council Personnel Committee would have the right to review appointments of major policy making officials and of CSW's. The Task Force was divided on the issue of whether the Personnel Committee should review all appointments. All state employees working with children in the area, unless specifically under the direction of state-level staff would be responsible to the area Director.

The structure being suggested depends for adequate implementation on the employment of competent personnel at both the state and the area level. The range of responsibility offered should attract such individuals. It is essential that these agencies be staffed with individuals knowledgeable about the needs of children. Children have special needs, different from those of adults. Those who work with children should be experts in child development, either through experience or training.

Controls

Area Councils would not be completely autonomous. They would be required to operate within guidelines established by the state children's services agency. If the state director believed that an area Council was not functioning according to these standards, he would recommend to the state Council that all or part of the area's funds be withheld until the situation improved. If after a public hearing a majority of the members of the state Council agreed, services would be administered by the state office until the area Council provided a plan which met with the approval of the state Council.

The Choice of Strategies

The Task Force was not so naive as to believe that either local control, represented by area Children's Councils, or multipurpose centers, represented by the Children's Service Centers, would solve the problems

of service delivery. Both these concepts have been tried before, although not in a system devoted exclusively to children, and both have been found to create problems as well as to solve them. The movement toward decentralization of responsibility for services from high levels of governments into the hands of the recipients of the services derives in part from the Community Action Program of the Office of Economic Opportunity. It has brought with it many changes in education, social services, and health particularly, and an increase in accountability to consumers. Although local control may sometimes not be the most efficient method of designing services, and at times may lead to conflict, the positive effects seem to outweigh the negative ones.[3] The Task Force feels the application of the concept of local control to the problems of children would result in increased responsiveness.

Multiservice centers also have experienced an increase in popularity as a result of the anti-poverty program. Some reports have praised them for their effectiveness;[4] others have taken a more balanced position recognizing their strengths and weaknesses.[5] But such centers are the best mechanism currently available to assist individuals through a complicated delivery system which does not seem to have been designed to make it easy for the consumer. Improved access to services is an important issue confronting American society. "There is still a need for a general, multipurpose doorway to the entire social service system, a place for infomation-advice-referral on a broad range of issues, an organization dedicated to case advocacy as needed."[6] The Task Force feels the multi-service center,[7] adapted to the needs of children, together with area Children's Councils would represent a major step in the implementation of the preventive approach to the problems of children.

REFERENCES

1 - Governor's Committee on Child Abuse, Final Report, Commonwealth of Massachusetts, October 6, 1971.

2 - Alan R. Gruber, Foster Home Care in Massachusetts: A Study of Foster Children - Their Biological and Foster Parents, Governor's Commission on Adoption and Foster, Commonwealth of Massachusetts, 1973.

3 - See, for example, "Curriculum Essays on Citizens, Politics, and Administration in Urban Neighborhoods", Public Administration Review, 32, October, 1972, Special Issue.

4 - See, for example, William J. Sahlein, A Neighborhood Solution to the Social Services Dilemma, Lexington Books, D.C. Heath and Company, Lexington, Mass., 1973. Used with permission of the publisher.

5 - Robert Perlman and David Jones, Neighborhood Service Centers U.S. Department of Health, Education, and Welfare, 1967.

6 - Alfred J. Kahn, "Perspectives on Access to Social Services," Social Work, 15, April 1970, 95-101.

7 - See also Toward A Comprehensive Service Delivery System Through Building the Community Service Center, U.S. Department of Health, Education, and Welfare, 1970.

CHAPTER VII

A NEW STATE AGENCY FOR CHILDREN

Although the area Children's Councils and their staffs would have the primary responsibility for ensuring that the needs of children were met, the areas would be dependent on a state children's services agency for a variety of essential services. The state agency would establish and enforce standards for the types and quality of programs to be offered in all areas, and would do state-wide planning and budgeting. Paralleling the organization on the area level, the state agency would operate under the direction of a state Children's Council.

Functions

The state agency would have two types of responsibilities: to assist area Children's Councils and their staffs in planning and delivering services at the local level, and to conduct certain specialized activities at the state level.

Assistance to Area Agencies

In order to perform their activities effectively the area children's services agencies would require assistance from the state staff in several specific matters.

Guidelines: The state agency would develop guidelines for children's programs throughout the Commonwealth. These guidelines would indicate what services must be available to children in each area (see suggested list in Chapter V) and also what programs were needed at a regional or state level. It would set standards for those services, such as the maximum case load for a Children's Services Worker, the number of children allowable in a foster home, or the staffing for a residential facility for mentally ill children. Since knowledge of child development and of the services needed to assist children is constantly expanding, these guidelines should be reviewed periodically--utilizing suggestions for additions and revisions from the areas. The proposed new guidelines would be forwarded to the areas for implementation after approval by the state Council. The development of qualifications for various positions also would be a state agency responsibility.

Consultation: State personnel would be available to area Councils and staffs both for assistance with overall planning and in relation to specific technical services. A Council wanting advice on how to assess the needs in its area could request a consultant to meet with it; or a Council concerned with the quality of care in a day care center might ask a consultant to review and report on the situation. Although most consultations would be provided on the basis of a defined task, the state agency should be prepared to loan its personnel to area Councils on a temporary basis when the situation required a long-term commitment. The staff of specialists available to assist the area Councils and their staffs should not

only include professionals, such as physicians, dentists, nurses, social workers, psychologists, and others; but also individuals skilled in such areas as community organization, staff recruitment and training, and education of the public and of special populations.

Appeals: The state agency would be responsible for hearing appeals from area citizens or agencies who believed the area Council had not taken appropriate action. For example, if an area Council had terminated its contract with a day care center because it felt the center's services were inadequate, the center could appeal that decision. Individual citizens or agencies which felt that the area Council was not performing its functions satisfactorily could come to the state agency with their complaints. If after public hearing, the state Council agreed, it would have the power to order the state agency to administer all or parts of the area program under a "trusteeship" until the area Council had improved its operations.

Staff Development and Training: The state agency would arrange for pre- and in-service training of all area staff. Those aspects of the curriculum which cut across area lines, such as principles of child development, state guidelines, and state resources, could be taught in state-wide or regional seminars. Detailed information about local problems and resources should be discussed at the area level, if possible, with the participation of area staff. The state agency also should take an active part in upgrading the competence of other subprofessional and professional personnel including both those employed by the state and by private agencies. These educational functions should provide an additional opportunity for cooperation between the state children's services agency and several divisions of the Executive Office of Educational Affairs.

Budget: The state agency would be responsible for receiving, consolidating, and revising the budgets submitted by area Councils into a single unified area services budget and for preparing the budget for state level functions. Local Councils would be kept informed of the fate of their budget requests, but the state agency would make the final decision. The entire budget would be reviewed by the state Council before it was transmitted to the next level of government as the full agency budget.

The state children's services agency would be designated as the agency to receive all federal funds given to the Commonwealth for service programs (exclusive of AFDC and Medicaid).

State Level Functions

The state agency also would be responsible for a group of functions which would be relatively independent of its role in relation to the area Councils, although its activities in these fields would affect the areas; and also for those programs, services, and facilities which serve more than one area.

Advocacy: Although advocacy in relation to specific cases would be the function of CSW's and other staff at the area level and certain types of class advocacy would be handled by the area Councils; class advocacy at the state level would be an essential state agency function.[1] Class advocacy would focus on state policy, administrative procedures, budgets, and legislation. The state staff would need to interpret continually the special needs of children to other officials of state government, to legislators, and to others in policy-making positions. It also would have to monitor all state activities to determine whether any would affect children adversely. If proposed legislation or the regulations of another state agency might have a negative influence, the state staff would be expected to intervene directly or to bring this to the attention of its Council to determine what action should be taken. Examples might be regulations reducing the scope of services eligible for Medicaid reimbursement or legislation about adoption.

Agencies, such as the state children's services agency, whose primary responsibilities include planning, administrative, and direct service functions may find it difficult to play a strong advocacy role. For this reason organizations outside of government, such as the Massachusetts Committee on Children and Youth, should be encouraged to continue their important advocacy role. The state government's role in advocacy should not relieve all other agencies and individuals involved with children from this function. The Child Welfare League of America[2] has recommended that action be taken:

> to establish within the administrative structure of voluntary as well as public agencies, and in the community, procedures to assure that children will receive the services to which they are entitled, including appeal and grievance procedures, judicial review of agency decisions when services are denied or deemed unsatisfactory, and measures to ensure compliance.

Planning: The state agency should be the leader in analyzing the needs of children throughout the Commonwealth and in planning programs to meet these needs, although responsibility in this area should be shared with other governmental and private agencies. For example, Chapter 766 provides an excellent opportunity for cooperative planning with the Division of Special Education. To perform this task adequately, the state will need to employ personnel capable of collecting essential data. The short and long-term plans generated by the state staff would form a framework within which the guidelines for services would be generated and modified. The planning and guideline functions should be shared by the state and local staffs with suggestions going in both directions. Various research studies and the development and evaluation of demonstration projects also would fall within the planning function.

Monitoring and Evaluation: The state agency would be expected to monitor the activities of the area Councils. State personnel should regularly visit area Children's Service Centers and meet with area Children's Services Directors and Councils. Although the area Councils and their staffs would have the primary responsibility for evaluating the quality of their own services and those they purchase, the active presence of state staff would stimulate their activities in this area, give them experts with whom to discuss problems, and serve as additional safeguards that the needs of children were met.

Licensing: The state agency would develop the standards for licensing various types of facilities and periodically revise them. State staff would inspect all facilities applying for licenses, issue licenses if the standards were met, and revoke them if the quality of care fell below standards.

Inter-Agency Coordination: State staff would work with other state agencies, as well as private ones, in developing referral systems and other cooperative relationships. Proposals for collaborative arrangements with other state agencies might be initiated by the staff or might be conceived as a result of complaints from areas about problems in obtaining information or services. For example, a system would be needed to inform area staff when children needed care because a parent had been admitted to a state psychiatric hospital or had been imprisoned. These formal relationships among state agencies operating programs which affect children should be handled on the state level.

The only other state agencies which would have major responsibilities for children under the Task Force's plan would be Educational Affairs (schools)[3], Financial Assistance (AFDC), and Health Systems Regulation (Medicaid). The state children's agency should develop strong formal and informal ties with these agencies leading to collaborative programs and continual exchanges of information. This relationship should be paralleled at the area level where there would be many opportunities for joint services. The state children's agency also should maintain close ties with the judicial branch of the government since so many children are known to the courts and are placed on probation or in correctional institutions.[4]

Program Operation: The state agency would operate those programs, services, and facilities which were too specialized for the area Councils and which served more than one area. Although whenever feasible, preference would be given to small community-based programs, in some instances the scarcity of personnel and other resources and in others, the small volume of services required would make it essential to have certain specialized services remain a state function.

As discussed the the previous chapter, area Councils would pay for the care of their children in state facilities. If the reimbursements from the areas were less than the actual cost of operating a particular state facility, the state agency would have to reconsider the need for this facility. Such an arrangement would discourage the continuation of poorly operated or unnecessary facilities. Savings realized by the closing of state institutions should be transferred to the area agencies for support of those programs which provided alternatives to institutionalization.

Organization

Regional children's services offices with their own staffs and Councils would not be necessary in this plan. Such a superstructure would only impede the delivery of services by placing an additional layer of bureaucracy between the state level agency to whom the legislature provided funds and the area Councils which distributed them. The Task Force felt that the money which would be necessary to maintain regional offices could be better spent at the area level. This does not preclude the possibility of the state agency providing specific services on a regional basis.

The state Children's Council should include representatives of the area Councils as well as others chosen by the Governor. Consumers and providers of services should be represented equally.

The Governor would appoint the Director of the agency, who would make major staff appointments, subject to the review of the Council's Personnel Committee.

Position in State Governmental Structure

Although the Task Force was unanimous in its opinion that there be a single state agency responsible for serving the needs of children, it struggled unsuccessfully with the issue whether to recommend that the state agency responsible for children's services be (1) a separate Department (formerly designated Executive Office) whose Secretary would be a member of the Governor's cabinet, or (2) an Administration within the Department of Human Services whose Administrator would report to the Secretary of Human Services. Some members felt that the Department of Human Services was too large to give adequate attention to the problems of children, who comprise over a third of the state's population. Placing a Children's Services Administration within the Department might not only lead to competition for funds with the other Administrations, but also might increase the layers of bureaucracy with which individuals and agencies had to negotiate. A Secretary of Children's Services would have more status than an administrator and be closer to the sources of power, thus able to secure more resources for children. Also the structure of the proposed area and state children's services agencies would have trouble fitting within the proposed Human Services structure which calls for area and regional Human Services Councils, largely advisory in function, appointed by the Human Services Secretary.

Those opposing a separate Department pointed out that collaborative arrangements of various types, including joint use of institutions and referral systems, might be easier to develop within a Department than between Departments. Also an Administrator might be appointed primarily on the basis of professional qualifications, while a Secretary might be judged on more political considerations. In addition, the major changes recommended, i.e., giving power to area Children's Councils and developing Children's Service Centers, might receive more support from Department staff and their allies if such plans were not contingent on removing a large portion of its

BEST COPY AVAILABLE

current responsibility from the Department. The Task Force did not want a new Department of Children's Services created which only had advocacy responsibility, while the administration of personal services to children remained in the Department of Human Services.

The Task Force decided not to take a position on this issue. The members wished to reserve their energies for the struggle to release children's services from the existing agencies and to integrate them into a new agency, and not be diverted into a political battle concerning the level at which this new agency would be inserted in the state structure.

Checks and Balances

In this chapter and the preceding one, an organizational structure has been proposed which would require a delicate balance between state and area agencies. While attempting to make the delivery system more effective through the decentralization of control over most services, the recommendations give much power to the state agency and council in order to establish statewide standards and reach certain desired goals throughout the state. The centralization-decentralization issue need not be viewed entirely negatively; rather it has the potential for building checks and balances into the system which would keep both the state agency and its local counterparts from becoming rigid or complacent. Each will have to account to the other in all its activities and, if the tensions between them are not allowed to build up, the resultant force will have a positive effect on meeting the needs of children.

REFERENCES

1 - The Distinction between case and class advocacy is made in Alfred J. Kahn, et al, Child Advocacy: Report of a National Baseline Study, Columbia University School of Social Work, New York, 1972. Class advocacy is defined as "a category of action that seeks to prevent problems and difficulties or assure intervention on a 'wholesale' basis for those with problems and difficulties."

2 - Child Welfare League of America, A National Program for Comprehensive Child Welfare Services, New York , N.Y., 1971.

3 - Although the Task Force was aware of the important role of educational agencies and institutions in meeting the needs of children, it is not discussed in more detail in this report because of the limitations of time and space, and the absence from the Task Force of individuals with specific competence in this area.

4 - The problems of children within the court system are expected to be the subject of another MCCY report.

CHAPTER VIII

THE RECOMMENDATIONS IN ACTION

The most important consequence of the Task Force report would be a new look at the needs of children throughout the Commonwealth and a new dedication to meeting those needs. Little will be accomplished if responsibilities are shifted from old departments to new ones without a change in public priorities favoring children and more functional use of available funds, as well as increased appropriations. In fact, one of the objectives of establishing a large group of area Children's Councils is to create informed citizen groups which can engage in advocacy and social action in behalf of children. Each Council, in addition to its planning and service responsibilities, would mobilize citizen support for adequate appropriations and introduce, and promote enactment of, legislation to protect children's rights. Council members should not be allowed to become so involved in the administrative problems of an area that they neglect their potential for social action.

Implementing the Task Force's recommendations would mean that the children's services agencies would assume responsibility for all the personal services to children provided directly or purchased by the various Executive Offices, for those state institutions serving children predominantly, and for the various information, consultation, training, and licensing functions now handled by the Executive Offices. In many cases, the personnel who now perform these duties could be shifted laterally into the new children's services agency. Professionals in children's services within the present Departments could be moved into consultant and planning slots at the state level. After some retraining, state employees could be moved from local and regional offices in the current system into the new area Children's Service Centers as Children's Services Workers, supervisors, or consultants, or as area Directors or members of their staffs. The reorganization should result in a more efficient and responsive system, but in the absence of additional funds to implement the preventive approach or to change priorities so as to provide a healthier environment, the needs of children would still largely be unmet.

The recommendations would require two basic changes in state government, in addition to the shifting of service responsibilities; a restructuring of civil service regulations and a delegation of budgetary powers. The Task Force and many of the individuals who responded to its inquiry were distressed by the negative influence of the state's civil service system. Capable people who do not meet certain rigid specifications cannot be employed; incompetent people cannot be discharged; and the processing of positions is disastrously delayed. The legislature should modify the system to allow area and state Councils to employ people within the guidelines established by the state Council, and, equally important, to discharge those whom they find unsuitable for their jobs.

This report's recommendations also could be carried out more effectively if the legislature permitted the areas more responsibility for the expenditure of funds within guidelines established by the state. Fiscal autonomy is not being proposed here. The areas would prepare detailed budgets and these would be revised and integrated by the state agency so that the budget submitted to the legislature would spell out in detail the plans of state and local agencies for the utilization of funds in the coming year. But Councils should be allowed to shift funds from item to item, within stated limits, (perhaps ten per cent of the area budget) in order to meet situations which arise within the year. The budget should encourage them to capitalize on new opportunities and to respond to new challenges, not freeze them into rigid patterns. The conversion of the state budget system from a line to a program orientation would expedite this process and ensure that funds were used for the programs the legislature wanted to support, if not always for the exact kind of personnel or service specified in the budget prepared a year or more before the time for the expenditure of funds.

Finally, it has not been possible in this report to discuss every problem children in the Commonwealth face, or every need they have, or every service essential to satisfy those needs. Inadequacies in medical care, protective services, and juvenile justice have barely been mentioned. The legitimate demand for day care services, adequately supervised foster homes, and services for adolescents has only been suggested. The Task Force decided, however, not to stress particular problem areas, but rather to describe the overall situation; and not to make specific detailed recommendations, but to propose a sweeping reorientation and reorganization of services. If these recommendations are accepted and carried out, a system will be created for tackling the particular problems.

Bunker Hill Health Center

of the

Massachusetts General Hospital

73 High Street
Charlestown, Massachusetts 02129

John P. Connelly, M.D.
Executive Director

Area Code 617
Telephone 241-8800

Statement of Dr. Andrew D. Guthrie, Jr., Mel Shea, and Miss Margaret A. Sullivan

The undersigned are pleased to endorse the Report of the Task Force on Children's Services with one important exception. We do not believe it is appropriate for the Task Force to recommend as a preventive measure for unwanted pregnancies, in Chapter V, page 50, that "facilities should be developed at which abortions can be obtained, in line with good medical practice and state law."

We dissent from this recommendation for the following reasons:

i) Abortion is a practice considered morally objectionable by a significant portion of our citizenry. These citizens feel that abortion denies the most fundamental right of children - the right of life itself.

ii) The question of abortion is currently the subject of a major public debate at nearly every level of society. It is not a settled question despite the Supreme Court decision of January 1973. We believe it is unnecessary and inappropriate for the Task Force to make a recommendation such as the one cited in the midst of this debate.

iii) The suggestion itself is without merit as a preventive measure on behalf of children. Abortion is an alternative to the completion of pregnancy that serves the parents and not the child or society and how well it serves the parents is a highly questionable issue.

(signed) Andrew D. Guthrie, Jr., M.D.
Director, Ambulatory Division, Children's Services, Massachusetts General Hospital

(signed) Mel Shea, Executive Director
Eastern Middlesex Opportunity Council

(signed) Margaret A. Sullivan,
Executive Secretary, Catholic Charitable Bureau of Boston